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# *AFFORDABLE ASSISTED LIVING DEMONSTRATION INITIATIVE*

# MICHIGAN STATE HOUSING DEVELOPMENT AUTHORITY
# DEPARTMENT OF COMMUNITY HEALTH
# DEPARTMENT OF HUMAN SERVICES
# OFFICE OF SERVICES TO THE AGING

# REQUEST FOR CONCEPT PAPERS

**DATE: August 4, 2006**

## SECTION I
## General Information for Bidders

**PROPOSAL DESCRIPTION/PURPOSE:**

The Michigan State Housing Development Authority (MSHDA), together with the state Department of Community Health (DCH), the Department of Human Services (DHS) and the Office of Services to the Aging (OSA), seeks five or more concept papers to describe the construction, rehabilitation or retrofitting of Affordable Assisted Living projects (AALs) that will be made affordable to low and moderate income Michigan residents. A minimum of 20% of the units must be affordable to households with incomes of 50% of the area median income or less. This Assisted Living should include long-term care options on-site, nearby, or be linked to or part of a larger Continuing Care Retirement Community (CCRC) model of senior living. The selection of concepts to be funded will be determined by the options proposed to allow seniors to maintain independence in their own home or in the same neighborhood. Because this is a new senior housing option, MSHDA, DCH, OSA and/or DHS and those submitting concepts will work in partnership to craft housing plans and options to begin to create models of Affordable Assisted Living in Michigan. Mixed income developments are encouraged and segregation of low income housing from non-low income housing is not permitted. Special Medicaid waivers and new provisions may be required to complete this initiative.

The CCRC model is recognized as providing a range of housing and health care options serving senior households, possibly including but not limited to independent living, assisted living, home health care and licensed skilled nursing care on the same general site. Alternatively, a partnership with other entities providing extended services may be utilized. The specific care elements to be provided and linkages to other senior housing options are left to the applicant to define.

The conventional market is providing CCRCs for those senior households able to afford them. Such conventional CCRCs often include an up-front “buy-in” fee and monthly rent/service charges. In return, the conventional CCRC model often includes a guarantee for housing and service provision for the life of the resident, regardless of future ability to pay, given certain assumptions and constraints.

MSHDA has long been successful at financing independent and congregate rental properties affordable to low and moderate-income senior households. Often these households, when their care needs increase, must move to nursing homes based on an inability to afford skilled nursing

care or other assistance from a home health care provider, assisted living, or other options to have their needs met in a non-institutional setting. The specific housing and service provision model proposed must meet relevant state licensing standards, if applicable. This demonstration initiative seeks to combine affordable housing with access to Medicaid funding for the provision of home-based medical and non-medical services to seniors. Residential units funded under this demonstration must include both kitchen and bath facilities.

A critical component of successful projects will be the inclusion of the concept of "Person-Centered-Planning" (PCP).[1] Simply, PCP proposes to leave the maximum decision making capacity with the senior and their chosen advisors in terms of decisions related to the choice of supports coordinator, development of a supports plan, choice of service providers, and choice of residency. To this end, applicants must demonstrate how they will cooperate to ensure access to information about the range of housing choices and services to be provided as part of the overall application. Residents must be free to choose on or off site services for food, laundry, healthcare, etc., and cannot be required to use on-site services.

In order to demonstrate PCP principles, an applicant might include provision of written brochures and materials about the range of housing and service choices on-site and which, if any, services might be available to help keep seniors independent. It is hoped these pilot senior Affordable Assisted Living projects can serve as a resource for seniors throughout the community in which they are located, strengthen the linkages between local senior service providers, and foster cooperation with and complements to the local Area Agency on Aging.

Cooperation with Single Points of Entry: Single Points of Entry (SPE) is a pilot initiative by the Michigan Department of Community Health that began operation on July 1, 2006. Building on the desire to foster PCP described above, SPEs prescribe requirements for community involvement in the creation and governance of the initiative, collaboration with a wide range of stakeholders in the service provision and aging community and have at their core the desire to assist seniors to remain independent and in charge of decisions affecting their lives as long as possible. If proposals are within the geographic confines of a SPE, they must collaborate with and include the SPE as a partner in the application as it relates to the provision of services to Medicaid recipients. If your proposal is chosen as a demonstration AAL and a SPE is subsequently identified in your area, you must request that SPE participate in your project. Additional information related to the SPEs in Michigan can be found at the MDCH website here:

http://www.michigan.gov/mdch

The MDCH has identified the following "principles" regarding the use of the Medicaid waiver benefits, which must be adhered to in your application and subsequent use of the waivers:

1. There will not be separate Medicaid units. "Market rate" and "subsidized" units will be indistinguishable from each other in terms of physical attributes, layout, etc.
2. Services must be eligible for Medicaid reimbursement.
3. Service plans must be developed through a person-centered process.
4. Eligibility for the Medicaid waiver will be determined by a DCH designated agent.
5. Medicaid waiver beneficiaries must be afforded a choice of service providers. There shall be no prohibition against outside entities providing services in the development.

[1] Person Centered Planning is a process being introduced to Long Term Care by the Department of Community Health.

6. If a recipient with a waiver moves from the development, the recipient retains use of the waiver (if still eligible) and the development will be allowed to accept a new waiver-eligible recipient as a replacement for the recipient who left.
7. Advances of Medicaid reimbursement may be allowed based on a reasonable projection of service provision and cost but must be cost-settled on a quarterly or periodic basis.

Financing: MSHDA will provide financing through its tax-exempt and taxable direct lending programs that may be combined with federal HOME funds. Proposals submitted through the taxable program must compete for 9% tax credit allocations. Developments will be underwritten using the current parameters for these programs, available on MSHDA's website under the "Combined Application for Rental Housing Programs." If the proposal involves the partial or complete retrofit of an existing affordable senior facility, MSHDA may award a HOME loan or grant of up to $1.5 million to help cover the cost of the rehabilitation efforts.

Medicaid Waiver: The Michigan Department of Community Health has committed up to 380 Home and Community Based Medicaid Waiver slots (approximately $6 million in project-based Medicaid funding) for residents of these proposed AAL projects in order to assist with the cost of health services and supports. Residents must meet Medicaid income and functional eligibility and health screening criteria. This screening is done by SPEs or waiver agents in most situations. Service providers must meet Medicaid provider standards and understand the limitations of allowable benefits. The purpose of this allocation is to allow residents of these AAL projects who are or who become Medicaid eligible to receive long term care Medicaid health and support services within the matrix of services provided, contracted, or arranged for by the DCH designated waiver agent. This MDCH Medicaid commitment helps to foster the goal of supporting elderly residents to maintain independence.

Meal Service: Assisted Living typically involves the provision of meals on site. The Food Assistance Program is available to those residents meeting income criteria for that program. The Food Assistance Program, commonly known as "food stamps," can be used to purchase food at stores or through congregate meal sites, if the necessary technology is secured from the United States Department of Agriculture (USDA). Various eligibility requirements for the Food Assistance Program can be found online at:

http://www.michigan.gov/dhs/0,1607,7-124-5453_5527-21832--,00.html

Developers interested in encouraging residents to use Food Assistance can partner with a new demonstration program called "MiCAFE." MiCAFE was piloted in Genesee County and subsequently expanded to include Branch, Cass, Eaton, Gratiot, Kalamazoo, Emmet, St. Joseph and Wayne Counties. It seeks to increase seniors' participation rates in the Food Assistance Program. It is expected that any concept paper from a MiCAFE county will address the use of this resource in its application. To the extent that MiCAFE expands beyond these counties, other applicants should investigate participation or cooperation with this program. Further information is available at www.micafeonline.org or by calling Elder Law of Michigan at 517-485-9164.

Food assistance is primarily a benefit for individuals to use to purchase food, not prepared meals. To become a congregate meal site that accepts Food Assistance via Bridge Cards, special arrangements will need to be made with the local Area Agency on Aging and the USDA.

Geographic Distribution: The demonstration has commenced with a CCRC proposed in East Lansing that has served as a working example to launch the collaborative process supporting

this initiative. Because the state entities involved consider this initiative to be a demonstration project, and hope to learn from various models, we intend to select at least one qualified AAL demonstration in Detroit, at least one in a predominately rural area of the state, and the remaining demonstrations according to the relative strength of concept papers received.

Evaluation Efforts: Sponsors of selected demonstrations must commit to engage in an evaluation of the demonstration program, and agree to cooperate with MSHDA and other partners in the future to perform any evaluation functions deemed appropriate to assist with the replication of this model. This may include the collection of data beyond what is generally collected and reported as part of standard MSHDA loan oversight. This evaluation effort will be discussed and negotiated during the mortgage underwriting process.

**INCURRING COSTS:**

The State of Michigan is not liable for any costs incurred by applicants during the application process. Selected applicants will be required to meet MSHDA's current underwriting guidelines for the applicable mortgage product they intend to use for financing. Costs related to the administration of Medicaid Waivers are also not reimbursable until a contract with the DCH is signed.

Notice of successful application for this AAL demonstration model does not guarantee a successful MSHDA mortgage loan.

**PRE-SUBMISSION QUESTIONS:**

All questions concerning this demonstration project must be in writing and submitted to MSHDA. E-mailing questions is preferable; they should be directed to Gabe Labovitz at labovitzg@michigan.gov. Written answers to questions will be collected and provided to ALL known prospective bidders. Questions submitted during the last SEVEN calendar days before the due date may not be answered.

MSHDA and the other state partners will convene a meeting on **August 30, 2006, 1:00** at MSHDA's office in Lansing to allow prospective applicants to ask questions of state partners to clarify issues of concern. All applicants who may apply are strongly encouraged to attend this meeting. We recommend you also research programming and assistance that may be made available from your local Area Agency on Aging, and reference Single Points of Entry, it at all possible in your proposal.

**PROPOSALS:**

The proposal must include a statement regarding the intent and ability of the applicant to pursue funding and implement the proposed AAL demonstration. It is expected that selected applicants will have the technical capacity to carry out the project significantly as proposed. Changes in the design, layout or services to be offered are discouraged, and will require involvement and approval by any or all state partners.

**FOLLOW-UP DISCUSSION:**

Applicants may be requested to provide follow-up information about their concept, either orally or in written format. This follow-up, if warranted, will provide an opportunity for both parties to clarify their intent, if necessary, with regard to this AAL initiative.

## ACCEPTANCE OF CONCEPT PAPER CONTENT:

Successful selection of an AAL demonstration shall become binding insofar as the applicant and their partner organizations must commit to follow through on the application for, and if a mortgage is made, development of the senior housing and service provision. MSHDA, DCH, OSA or DHS staff will make every effort to assist successful applicants as they assemble their application package(s) for MSHDA and other financing, and commit to working with applicants to the extent possible.

## ECONOMY OF PREPARATION:

Each proposal should be prepared simply and economically, providing a straightforward, concise description of the bidder's ability to meet the requirements of the demonstration. Extravagant presentation, such as bindings, color displays, promotional material, etc., will receive no evaluation credit. Emphasis should be on completeness and clarity of content.

## SELECTION CRITERIA:

A panel consisting of staff from MSHDA, DCH, DHS and OSA will review proposals received. Proposals will be evaluated on the following criteria:

### Threshold Criteria:

- Feasibility of Proposal: Costs appear to be reasonable and an efficient use of resources, as demonstrated by a preliminary pro forma. A preliminary market analysis or feasibility study confirms the mix of housing and service options, based on size of development, can be financially viable and sustainable long term. **(No points; this is a threshold standard that must be met)**
- Medicaid Approved Home Health Care Providers: Are the proposed providers approved by Medicaid? This presupposes a minimum standard of care and capacity to deliver in-home services to seniors. **(No points; this is a threshold standard that must be met)**
- Affordability: Minimum of 20% of units affordable to households at 50% of area median income. **(No points; this is a threshold standard that must be met)**

### Scoring Criteria:

Development Team Capacity:

- Experience of Sponsor and Partners: Evidence of successful provision of housing and services to senior populations. Show examples, provide references, call out case studies, whatever means you believe best show your capacity to incorporate and deliver the specifics of your AAL project. **(19 Points)**
- Competency in Underwriting: Ability of applicant to successfully underwrite a senior proposal with MSHDA, including an acceptable development team and management company. Evidence of site selection/control. Site represents a "positive" residential environment, including walkability, proximity to needed goods and services, medical care, availability of public transit, etc. Preliminary site design and layout, with emphasis placed on barrier free designs and universal design principals will be considered in this factor, as well as environmental factors. **(14 Points)**

Partnerships Created/Impact on Seniors Quality of Life:

- Partnerships Created or Expanded: Demonstrate involvement in the planning process of local senior citizens, senior citizen advocacy groups, aging network and community service organizations, disability network, the local Area Agency on Aging, and/or MiChoice Waiver Agent. Describe the partnerships to be created or expanded in the proposed demonstration. In what ways will such creation/expansion take place? Can you positively identify these partnerships? The more firm these partnerships or commitments can be shown to be, the better. Partnering with a hospital or other licensed health care provider is crucial, as people often go from independent living/congregate facilities into hospitals, and are in turn discharged from hospitals. **(19 Points)**
- Comprehensiveness of Senior Housing, Service and Support Options: Describe the health, mental health, community, and in-home social and day-to-day living services available or in close proximity to allow seniors to successfully maintain independence. **(14 Points)**

Miscellaneous Criteria:

- Local Contributions: Provide detail on donated land, tax abatement, infrastructure improvements, local provision of Section 8 Housing Choice Vouchers, etc. Again, the more firm such contributions can be shown to be, the stronger your application will be viewed. **(10 Points)**
- Income Targeting Proposed: How many units are to be targeted to low and moderate-income senior households? How deep is the income/rent targeting proposed to be? How many units will shelter seniors that meet Medicaid income/medical needs criteria? DHS Food Assistance Program eligibility? What subsidies or other resources may be made available to increase affordability for residents? **(14 Points)**
- Replicability of Demonstration Project: Will the demonstration advance our understanding of how to provide housing and services to low and moderate-income senior residents? Will the proposal be readily replicable? Will the model transfer to similar communities? Does the model include expanding existing partnerships with service providers, creating new partnerships, other? If the proposal is for the retrofit of an existing senior property, how can this (retrofit) process best be replicated elsewhere? How would you propose documenting lessons learned? **(10 Points)**

## CHANGES IN DEMONSTRATION:

Changes in the Demonstration as the result of a response made to questions or concerns or through correspondence will be put in writing to all known bidders and posted on our website until seven working days prior to the concept due date. MSHDA will make every effort, but does not commit, to answering questions during the last seven working days prior to the concept due date.

## DISCLOSURE:

All information in an applicant's proposal is subject to disclosure under the provisions of Public Act 442 of 1976, commonly known as the "Freedom of Information Act". This act also provides for the complete disclosure of documents and attachments hereto.

## SECTION II
## Information Required from Applicants

Proposals must be submitted in the format described below. There should be no attachments, enclosures or exhibits other than those considered by the applicant to be essential to a complete understanding of the proposal. Each section must be clearly identified with appropriate headings.

**BUSINESS ORGANIZATION:**

State the full name and address of your organization and, if applicable, the branch office or subordinate element that will perform, or assist in performing, the work described. Indicate whether it operates as an individual, partnership, corporation or a Limited Liability Company. If as a corporation, include the state in which it is incorporated. If applicable, indicate if it is licensed to operate in the State of Michigan.

Include similar identification for all proposed service providers. State whether the service providers have the capacity to perform the services identified and why you believe this to be the case. Include relevant references or case studies of such efforts for each service provider, including name of site, address, services provided and a contact that can address questions or concerns about the providers' ability to fulfill such service obligations.

**CONCEPT DESCRIPTION:**

- Narrative: Include a narrative summary description of the concept, including the total number of assisted living units proposed. Include a pro forma for housing development costs and residential rents and rental operating costs. Use MSHDA's electronic version of a pro forma. Identify the amount of HOME funds and MSHDA financing (tax-exempt or taxable) anticipated.

- Description of Services to be Provided, Partnerships to be Engaged: Provide a description, with all appropriate identifying documentation, of the services to be provided, by what service providers and their credentials/licensure, at what cost and when such services are expected to be made available. References are critical. While confirmation of such partnerships is not required at this stage, such partnership confirmation will be required to move forward, and the more firm such partnerships can be shown to be, the greater comfort the review panel will have with your application. Letters of support from partnering agencies would be considered a minimum element for this issue. If partnerships are not secured before the financing can be finalized, MSHDA reserves the right to delay or deny the project. If applicable, include license or certification number(s).

- Prior Experience: Indicate prior experience of your firm and partner firms that you consider relevant to the successful accomplishment of the project defined by this Demonstration. Include sufficient detail to demonstrate the relevance of such experience. Again, references are critical.

- Timeline: Include a timeline of when you propose to meet selected benchmarks in the process. Examples include meeting with MSHDA and other state staff to discuss the

concept in depth, when you propose to submit the proposal for Initial Determination, when the proposal might reasonably be expected to be submitted for final Underwriting and be presented to the MSHDA Board, when initial closing might occur, the date of construction and the date of initial occupancy.

- Bidder's Authorized Expediter: Include the name and telephone number of person(s) in your organization authorized to expedite this process with MSHDA, DCH, DHS and OSA.

- Additional Information and Comments: Include any other information that is believed to be pertinent but not specifically asked for elsewhere.

**CONCEPT SUBMISSION:**

Submit *eight* copies of your concept paper. Papers must be received by **5:00 PM, September 29, 2006.** It is anticipated the MSHDA/DCH/DHS/OAS review will take six weeks and the selected proposals will be announced on November 13, 2006.

Address for proposals submitted by Contract Carrier, Courier Delivery, or Personal Delivery is:

Gabe Labovitz
Michigan State Housing Development Authority
735 E. Michigan Avenue
Lansing, MI 48912

Proposals submitted through U.S. Postal Service should be addressed as follows:

Gabe Labovitz
Michigan State Housing Development Authority
P.O. Box 30044
Lansing, MI 48909

The Michigan State Housing Development Authority is within the state Department of Labor and Economic Growth. Section 209 of Public Act 156 of 2005 states: "Preference should be given to goods or services, or both, manufactured or provided by Michigan businesses if they are competitively priced and of comparable quality."

STATE OF MICHIGAN
DEPARTMENT OF COMMUNITY HEALTH
LANSING

JENNIFER M. GRANHOLM
GOVERNOR

JANET OLSZEWSKI
DIRECTOR

Date: September 15, 2006

To: Members, Long Term Care Supports and Services Advisory Commission

From: Michael J. Head, Director, OLTCSS

Subject: Affordable Assisted Living Demonstration Initiative

As presented at your last Commission meeting, the Michigan State Housing Development Authority (MSHDA), together with the state Department of Community Health (DCH), the Department of Human Services (DHS) and the Office of Services to the Aging (OSA) have been working over several months to develop a request for concept papers to describe the proposed construction, rehabilitation or retrofitting of assisted living units that will be made available and affordable to low and moderate income Michigan residents. The initiative seeks to combine affordable housing with Medicaid funding for the provision of home-based supports and services in assisted living units. The selection of projects to be funded will be determined by the breadth and scope of options proposed to allow individuals to maintain independence in their own home or neighborhoods. The initiative is focused primarily at senior citizens.

A critical component will be the inclusion of person centered planning, placing maximum decision-making capacity with the senior and his/her chosen advisor. Applicants (developers) must demonstrate how they will cooperate with established entities to ensure access to full information about the range of housing choices and services to the provided as part of the overall application. Residents must be free to choose services that are provided by an outside vendor and cannot be required to use the services of the housing provider.

Projects must adhere to the following principles in the use of Medicaid waiver funding:

1. Market rate and subsidized units will be indistinguishable from each other in terms of physical attributes, layout, etc. Each unit must include both kitchen and bath facilities.
2. Services provided must be eligible for Medicaid reimbursement.
3. Service plans must be developed through a person centered process.
4. Eligibility for Medicaid will be determined by a DCH designated agent.
5. Medicaid waiver beneficiaries must be afforded freedom of choice. There shall be no prohibition against outside, unrelated entities providing services in these units.

6. The waiver is assigned to the consumer, not the unit. If a consumer funded with a waiver moves from the development, the consumer retains use of the waiver as long as eligibility is maintained.
7. Costs will be settled on quarterly or periodic basis.

MSHDA will provide financing for the housing. DCH has committed up to 380 waiver slots to assist with the cost of services and supports. This commitment is intended to foster the goal of supporting elderly residents to maintain independence.

A bidders' meeting was held on August 30, allowing interested developers an opportunity to ask questions and seek clarification from the state departments involved. Office staff served as a resource during the Q&A portion of that event. A representative from the Office will participate on the proposal review and selection panel.

Office staff will update you periodically on the progress of this initiative.

MH/JC

HHS News
U.S. Department of Health and Human Services
www.hhs.gov/news

FOR IMMEDIATE RELEASE
Friday, Sept. 15, 2006

Contact: CMS Office of Public Affairs
(202) 690-6145

**STATES GET FEDERAL GRANTS TO HELP PEOPLE WITH DISABILITIES LIVE IN THE COMMUNITY**

HHS Secretary Mike Leavitt today awarded nearly $20 million in grants to states to develop programs for people with disabilities or long term illnesses. The "Real Choice Systems Change Grants for Community Living" will help states and territories "rebalance" their long-term support programs to help people with chronic illness or disabilities to reside in their homes and participate fully in community life.

"These grants will help states take full advantage of the opportunities to reform their Medicaid long-term care systems offered by the recently passed Deficit Reduction Act of 2006 and remove barriers to equality for the 54 million Americans living with disabilities," Secretary Leavitt said. "They will help persons with disabilities exercise meaningful choices about how and where to live their lives."

The Bush Administration has promoted the goal of community living for people with disabilities through the *New Freedom Initiative.* Under this initiative 10 federal agencies have collaborated to remove barriers to community living. The additional funding for "Real Choice Systems Change Grants for Community Living" approved by Congress for 2006 will augment efforts begun in FY 2001 to help states improve their community-based services.

"The grants awarded today will help states make lasting improvements to their home and community based services programs," said Mark B. McClellan, M.D., Ph.D., administrator of the Centers for Medicare & Medicaid Services (CMS). "This program is vital in helping Medicaid move from its institutional bias to a program that truly meets the needs of people who depend upon it." The eight states receiving 2006 awards are; California, Virginia, Michigan, North Carolina, New York, New Jersey, Rhode Island and Kansas.

Since 2001, CMS has awarded 306 Real Choices grants, totaling approximately $237 million to 50 states, Guam, the Northern Mariana Islands and the District of Columbia.

For this round of grant awards, CMS will require states receiving grant money to address at least three of the six goals necessary to transform Medicaid program incentives away from institutional care with options for care at home and in the community. The goals include:

- Improving access to information regarding the full range of community-based services available;
- Promulgation of more self-directed service delivery systems;
- Implementation of comprehensive quality management system;
- Development of information technology to support community living;
- Flexible financing arrangements that promote community living options; and
- Long-term supports coordinated with affordable and accessible housing.

- More -

By providing important support for rebalancing long-term care services, the Real Choice Systems Change program has paved the way for the much more extensive options now available to states since the passage of the Deficit Reduction Act of 2006 to help states create greater opportunities for community living. The centerpiece of these efforts is a major new funding opportunity for states through the Money Follows the Person Rebalancing Demonstration.

This demonstration provides up to $1.75 billion to eligible states to transition individuals from institutions who want to live in the community and rebalance their entire long-term care system to ensure individuals have a choice of where they want to live and receive services. While applications for this demonstration are not due until Nov. 1, 35 states have expressed interest in applying.

For more information on the New Freedom Initiative, visit the CMS Web site at: http://www.cms.hhs.gov/newfreedom/.

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# Evaluating Michigan's Single Point of Entry Demonstration Projects

Stakeholder Informational Forum

September 25, 2006

# SPE Evaluation Drivers

- LTC Task Force Report Benchmarks
- Aging & Disability Resource Centers Grant (Administration on Aging & CMS)
- SPE contract Statement of Work
- LTC Commission: "Recommend a performance evaluation of the SPE demonstration projects" (Executive Order 2005-14)
- Legislature:
  - Appropriations boilerplate language
  - HB 5389:
    - Performance elements
    - Independent evaluation of cost-benefit

# Steps to Successful Evaluation

- Define critical performance outcomes and process elements to be the subjects of monitoring and evaluation
  - Key questions derived from evaluation drivers
- Identify performance standards and benchmarks to determine measurement criteria
- Determine data collection methods:
  - Project activity and cost reports
  - Service Point data system
  - Customer feedback
    - Consumers & family members utilizing SPE services
    - Collaborating partners
  - Medicaid LTC service costs
- Compare "evidence" to the standards and benchmarks
- Process the results to address evaluation questions
- Manage/eliminate bias in reaching conclusions

# Stakeholders

- Individuals who utilize the SPE services
  - Persons needing LTC assistance
  - Their family members/friends
- Referral/disposition collaborators
  - Providers of health and long-term care services
  - Dept. of Human Services
  - Area Agencies on Aging
- Consumer advocates
- SPE staff & governing board members; Advisory Board
- State:  MDCH, LTC Commission, OSA, DHS, Governor, Legislature

# Development Process

- Retain evaluation design consultant
- Engage LTC Commission in development process
- Involve SPE Demonstration entity governance and advisory boards
- Involve collaborative partners
- Determine evaluation design
- Engage independent entity to manage the evaluation process (by January, 2007)

# Expectations

- Annual reports:
  - FY 2007 – by December 2007
  - FY 2008 – by December 2008
- Legislative report
  - Per boilerplate requirements
  - Progress report during FY 2008 budget process
  - Preliminary outcomes report during FY 2009 budget process
- Evaluation findings used to course-align SPEs and design for SPE expansion to statewide

**SUBSTITUTE FOR**

**HOUSE BILL NO. 5389**

A bill to amend 1939 PA 280, entitled

"The social welfare act,"

(MCL 400.1 to 400.119b) by adding sections 109i and 109j.

**THE PEOPLE OF THE STATE OF MICHIGAN ENACT:**

**SEC. 109I. (1) THE DIRECTOR OF THE DEPARTMENT OF COMMUNITY HEALTH SHALL DESIGNATE AND MAINTAIN LOCALLY OR REGIONALLY BASED SINGLE POINT OF ENTRY AGENCIES FOR LONG-TERM CARE THAT SHALL SERVE AS VISIBLE AND EFFECTIVE ACCESS POINTS FOR INDIVIDUALS SEEKING LONG-TERM CARE AND THAT SHALL PROMOTE CONSUMER CHOICE AND QUALITY IN LONG-TERM CARE OPTIONS.**

**(2) THE DEPARTMENT OF COMMUNITY HEALTH SHALL MONITOR SINGLE POINT OF ENTRY AGENCIES FOR LONG-TERM CARE TO ASSURE, AT A MINIMUM, ALL OF THE FOLLOWING:**

**(A) THAT BIAS IN FUNCTIONAL AND FINANCIAL ELIGIBILITY**

**DETERMINATION OR ASSISTANCE AND THE PROMOTION OF SPECIFIC SERVICES TO THE DETRIMENT OF CONSUMER CHOICE AND CONTROL DOES NOT OCCUR.**

**(B) THAT CONSUMER ASSESSMENTS AND SUPPORT PLANS ARE COMPLETED IN A TIMELY, CONSISTENT, AND QUALITY MANNER THROUGH A PERSON-CENTERED PLANNING PROCESS AND ADHERE TO OTHER CRITERIA ESTABLISHED BY THIS SECTION AND THE DEPARTMENT OF COMMUNITY HEALTH.**

**(C) THE PROVISION OF QUALITY ASSISTANCE AND SUPPORTS.**

**(D) THAT QUALITY ASSISTANCE AND SUPPORTS ARE PROVIDED TO APPLICANTS AND CONSUMERS IN A MANNER CONSISTENT WITH THEIR CULTURAL NORMS, LANGUAGE OF PREFERENCE, AND MEANS OF COMMUNICATION.**

**(E) CONSUMER ACCESS TO AN INDEPENDENT CONSUMER ADVOCATE.**

**(F) THAT DATA AND OUTCOME MEASURES ARE BEING COLLECTED AND REPORTED AS REQUIRED UNDER THIS ACT AND BY CONTRACT.**

**(G) THAT CONSUMERS ARE ABLE TO CHOOSE THEIR SUPPORTS COORDINATOR.**

**(3) THE DEPARTMENT OF COMMUNITY HEALTH SHALL ESTABLISH AND PUBLICIZE A TOLL-FREE TELEPHONE NUMBER FOR AREAS OF THE STATE IN WHICH A SINGLE POINT OF ENTRY AGENCY IS OPERATIONAL AS A MEANS OF ACCESS.**

**(4) THE DEPARTMENT OF COMMUNITY HEALTH SHALL REQUIRE THAT SINGLE POINT OF ENTRY AGENCIES FOR LONG-TERM CARE PERFORM THE FOLLOWING DUTIES AND RESPONSIBILITIES:**

**(A) PROVIDE CONSUMERS AND ANY OTHERS WITH UNBIASED INFORMATION PROMOTING CONSUMER CHOICE FOR ALL LONG-TERM CARE OPTIONS, SERVICES, AND SUPPORTS.**

**(B) FACILITATE MOVEMENT BETWEEN SUPPORTS, SERVICES, AND SETTINGS IN A TIMELY MANNER THAT ASSURES CONSUMERS' INFORMED**

**CHOICE, HEALTH, AND WELFARE.**

**(C) ASSESS CONSUMERS' ELIGIBILITY FOR ALL MEDICAID LONG-TERM CARE PROGRAMS UTILIZING A COMPREHENSIVE LEVEL OF CARE ASSESSMENT APPROVED BY THE DEPARTMENT OF COMMUNITY HEALTH.**

**(D) ASSIST CONSUMERS IN OBTAINING A FINANCIAL DETERMINATION OF ELIGIBILITY FOR PUBLICLY FUNDED LONG-TERM CARE PROGRAMS.**

**(E) ASSIST CONSUMERS IN DEVELOPING THEIR LONG-TERM CARE SUPPORT PLANS THROUGH A PERSON-CENTERED PLANNING PROCESS.**

**(F) AUTHORIZE ACCESS TO MEDICAID PROGRAMS FOR WHICH THE CONSUMER IS ELIGIBLE AND THAT ARE IDENTIFIED IN THE CONSUMER'S LONG-TERM CARE SUPPORTS PLAN. THE SINGLE POINT OF ENTRY AGENCY FOR LONG-TERM CARE SHALL NOT REFUSE TO AUTHORIZE ACCESS TO MEDICAID PROGRAMS FOR WHICH THE CONSUMER IS ELIGIBLE.**

**(G) UPON REQUEST OF A CONSUMER, HIS OR HER GUARDIAN, OR HIS OR HER AUTHORIZED REPRESENTATIVE, FACILITATE NEEDED TRANSITION SERVICES FOR CONSUMERS LIVING IN LONG-TERM CARE SETTINGS IF THOSE CONSUMERS ARE ELIGIBLE FOR THOSE SERVICES ACCORDING TO A POLICY BULLETIN APPROVED BY THE DEPARTMENT OF COMMUNITY HEALTH.**

**(H) WORK WITH DESIGNATED REPRESENTATIVES OF ACUTE AND PRIMARY CARE SETTINGS, FACILITY SETTINGS, AND COMMUNITY SETTINGS TO ASSURE THAT CONSUMERS IN THOSE SETTINGS ARE PRESENTED WITH INFORMATION REGARDING THE FULL ARRAY OF LONG-TERM CARE OPTIONS.**

**(I) REEVALUATE THE CONSUMER'S ELIGIBILITY AND NEED FOR LONG-TERM CARE SERVICES UPON REQUEST OF THE CONSUMER, HIS OR HER GUARDIAN, OR HIS OR HER AUTHORIZED REPRESENTATIVE OR ACCORDING TO THE CONSUMER'S LONG-TERM CARE SUPPORT PLAN.**

**(J) EXCEPT AS OTHERWISE PROVIDED IN SUBDIVISIONS (K) AND (*l*),**

**PROVIDE THE FOLLOWING SERVICES WITHIN THE PRESCRIBED TIME FRAMES:**

**(*i*) PERFORM AN INITIAL EVALUATION FOR LONG-TERM CARE WITHIN 2 BUSINESS DAYS AFTER CONTACT BY THE CONSUMER, HIS OR HER GUARDIAN, OR HIS OR HER AUTHORIZED REPRESENTATIVE.**

**(*ii*) DEVELOP A PRELIMINARY LONG-TERM CARE SUPPORT PLAN IN PARTNERSHIP WITH THE CONSUMER AND, IF APPLICABLE, HIS OR HER GUARDIAN OR AUTHORIZED REPRESENTATIVE WITHIN 2 BUSINESS DAYS AFTER THE CONSUMER IS FOUND TO BE ELIGIBLE FOR SERVICES.**

**(*iii*) COMPLETE A FINAL EVALUATION AND ASSESSMENT WITHIN 10 BUSINESS DAYS FROM INITIAL CONTACT WITH THE CONSUMER, HIS OR HER GUARDIAN, OR HIS OR HER AUTHORIZED REPRESENTATIVE.**

**(K) FOR A CONSUMER WHO IS IN AN URGENT OR EMERGENT SITUATION, WITHIN 24 HOURS AFTER CONTACT IS MADE BY THE CONSUMER, HIS OR HER GUARDIAN, OR HIS OR HER AUTHORIZED REPRESENTATIVE, PERFORM AN INITIAL EVALUATION AND DEVELOP A PRELIMINARY LONG-TERM CARE SUPPORT PLAN. THE PRELIMINARY LONG-TERM CARE SUPPORT PLAN SHALL BE DEVELOPED IN PARTNERSHIP WITH THE CONSUMER AND, IF APPLICABLE, HIS OR HER GUARDIAN OR AUTHORIZED REPRESENTATIVE.**

**(*l*) FOR A CONSUMER WHO RECEIVES NOTICE THAT WITHIN 72 HOURS HE OR SHE WILL BE DISCHARGED FROM A HOSPITAL, WITHIN 24 HOURS AFTER CONTACT IS MADE BY THE CONSUMER, HIS OR HER GUARDIAN, HIS OR HER AUTHORIZED REPRESENTATIVE, OR THE HOSPITAL DISCHARGE PLANNER, PERFORM AN INITIAL EVALUATION AND DEVELOP A PRELIMINARY LONG-TERM CARE SUPPORT PLAN. THE PRELIMINARY LONG-TERM CARE SUPPORT PLAN SHALL BE DEVELOPED IN PARTNERSHIP WITH THE CONSUMER AND, IF APPLICABLE, HIS OR HER GUARDIAN, HIS OR HER AUTHORIZED REPRESENTATIVE, OR THE HOSPITAL DISCHARGE PLANNER.**

**(M) INITIATE CONTACT WITH AND BE A RESOURCE TO HOSPITALS WITHIN THE AREA SERVICED BY THE SINGLE POINT OF ENTRY AGENCIES FOR LONG-TERM CARE.**

**(N) PROVIDE CONSUMERS WITH INFORMATION ON HOW TO CONTACT AN INDEPENDENT CONSUMER ADVOCATE AND A DESCRIPTION OF THE ADVOCATE'S MISSION. THIS INFORMATION SHALL BE PROVIDED IN A PUBLICATION PREPARED BY THE DEPARTMENT OF COMMUNITY HEALTH IN CONSULTATION WITH THESE ENTITIES. THIS INFORMATION SHALL ALSO BE POSTED IN THE OFFICE OF A SINGLE POINT OF ENTRY AGENCY.**

**(O) COLLECT AND REPORT DATA AND OUTCOME MEASURES AS REQUIRED BY THE DEPARTMENT OF COMMUNITY HEALTH, INCLUDING, BUT NOT LIMITED TO, THE FOLLOWING DATA:**

**(*i*) THE NUMBER OF REFERRALS BY LEVEL OF CARE SETTING.**

**(*ii*) THE NUMBER OF CASES IN WHICH THE CARE SETTING CHOSEN BY THE CONSUMER RESULTED IN COSTS EXCEEDING THE COSTS THAT WOULD HAVE BEEN INCURRED HAD THE CONSUMER CHOSEN TO RECEIVE CARE IN A NURSING HOME.**

**(*iii*) THE NUMBER OF CASES IN WHICH ADMISSION TO A LONG-TERM CARE FACILITY WAS DENIED AND THE REASONS FOR DENIAL.**

**(*iv*) THE NUMBER OF CASES IN WHICH A MEMORANDUM OF UNDERSTANDING WAS REQUIRED.**

**(*v*) THE RATES AND CAUSES OF HOSPITALIZATION.**

**(*vi*) THE RATES OF NURSING HOME ADMISSIONS.**

**(*vii*) THE NUMBER OF CONSUMERS TRANSITIONED OUT OF NURSING HOMES.**

**(*viii*) THE AVERAGE TIME FRAME FOR CASE MANAGEMENT REVIEW.**

**(*ix*) THE TOTAL NUMBER OF CONTACTS AND CONSUMERS SERVED.**

**(*x*) THE DATA NECESSARY FOR THE COMPLETION OF THE COST-BENEFIT ANALYSIS REQUIRED UNDER SUBSECTION (11).**

**(*xi*) THE NUMBER AND TYPES OF REFERRALS MADE.**

**(*xii*) THE NUMBER AND TYPES OF REFERRALS THAT WERE NOT ABLE TO BE MADE AND THE REASONS WHY THE REFERRALS WERE NOT COMPLETED, INCLUDING, BUT NOT LIMITED TO, CONSUMER CHOICE, SERVICES NOT AVAILABLE, CONSUMER FUNCTIONAL OR FINANCIAL INELIGIBILITY, AND FINANCIAL PROHIBITIONS.**

**(P) MAINTAIN CONSUMER CONTACT INFORMATION AND LONG-TERM CARE SUPPORT PLANS IN A CONFIDENTIAL AND SECURE MANNER.**

**(Q) PROVIDE CONSUMERS WITH A COPY OF THEIR PRELIMINARY AND FINAL LONG-TERM CARE SUPPORT PLANS AND ANY UPDATES TO THE LONG-TERM CARE PLANS.**

**(5) THE DEPARTMENT OF COMMUNITY HEALTH, IN CONSULTATION WITH THE OFFICE OF LONG-TERM CARE SUPPORTS AND SERVICES, THE MICHIGAN LONG-TERM CARE SUPPORTS AND SERVICES ADVISORY COMMISSION, THE DEPARTMENT, AND THE OFFICE OF SERVICES TO THE AGING, SHALL PROMULGATE RULES TO ESTABLISH CRITERIA FOR DESIGNATING LOCAL OR REGIONAL SINGLE POINT OF ENTRY AGENCIES FOR LONG-TERM CARE THAT MEET ALL OF THE FOLLOWING CRITERIA:**

**(A) THE DESIGNATED SINGLE POINT OF ENTRY AGENCY FOR LONG-TERM CARE DOES NOT PROVIDE DIRECT OR CONTRACTED MEDICAID SERVICES. FOR THE PURPOSES OF THIS SECTION, THE SERVICES REQUIRED TO BE PROVIDED UNDER SUBSECTION (4) ARE NOT CONSIDERED MEDICAID SERVICES.**

**(B) THE DESIGNATED SINGLE POINT OF ENTRY AGENCY FOR LONG-TERM CARE IS FREE FROM ALL LEGAL AND FINANCIAL CONFLICTS OF INTEREST WITH PROVIDERS OF MEDICAID SERVICES.**

**(C) THE DESIGNATED SINGLE POINT OF ENTRY AGENCY FOR LONG-TERM CARE IS CAPABLE OF SERVING AS THE FOCAL POINT FOR ALL INDIVIDUALS, REGARDLESS OF AGE, SEEKING INFORMATION ABOUT LONG-TERM CARE IN THEIR REGION, INCLUDING INDIVIDUALS WHO WILL PAY PRIVATELY FOR SERVICES.**

**(D) THE DESIGNATED SINGLE POINT OF ENTRY AGENCY FOR LONG-TERM CARE IS CAPABLE OF PERFORMING REQUIRED CONSUMER DATA COLLECTION, MANAGEMENT, AND REPORTING.**

**(E) THE DESIGNATED SINGLE POINT OF ENTRY AGENCY FOR LONG-TERM CARE HAS QUALITY STANDARDS, IMPROVEMENT METHODS, AND PROCEDURES IN PLACE THAT MEASURE CONSUMER SATISFACTION AND MONITOR CONSUMER OUTCOMES.**

**(F) THE DESIGNATED SINGLE POINT OF ENTRY AGENCY FOR LONG-TERM CARE HAS KNOWLEDGE OF THE FEDERAL AND STATE STATUTES AND REGULATIONS GOVERNING LONG-TERM CARE SETTINGS.**

**(G) THE DESIGNATED SINGLE POINT OF ENTRY AGENCY FOR LONG-TERM CARE MAINTAINS AN INTERNAL AND EXTERNAL APPEAL PROCESS THAT PROVIDES FOR A REVIEW OF INDIVIDUAL DECISIONS.**

**(H) THE DESIGNATED SINGLE POINT OF ENTRY AGENCY FOR LONG-TERM CARE IS CAPABLE OF DELIVERING SINGLE POINT OF ENTRY SERVICES IN A TIMELY MANNER ACCORDING TO STANDARDS ESTABLISHED BY THE DEPARTMENT OF COMMUNITY HEALTH AND AS PRESCRIBED IN SUBSECTION (4).**

**(6) A SINGLE POINT OF ENTRY AGENCY FOR LONG-TERM CARE THAT FAILS TO MEET THE CRITERIA DESCRIBED IN THIS SECTION OR OTHER FISCAL AND PERFORMANCE STANDARDS PRESCRIBED BY CONTRACT AND SUBSECTION (7) OR THAT INTENTIONALLY AND KNOWINGLY PRESENTS BIASED INFORMATION THAT IS INTENDED TO STEER CONSUMER CHOICE TO PARTICULAR**

**LONG-TERM CARE SUPPORTS AND SERVICES IS SUBJECT TO DISCIPLINARY ACTION BY THE DEPARTMENT OF COMMUNITY HEALTH. DISCIPLINARY ACTION MAY INCLUDE, BUT IS NOT LIMITED TO, INCREASED MONITORING BY THE DEPARTMENT OF COMMUNITY HEALTH, ADDITIONAL REPORTING, TERMINATION AS A DESIGNATED SINGLE POINT OF ENTRY AGENCY BY THE DEPARTMENT OF COMMUNITY HEALTH, OR ANY OTHER ACTION AS PROVIDED IN THE CONTRACT FOR A SINGLE POINT OF ENTRY AGENCY.**

**(7) FISCAL AND PERFORMANCE STANDARDS FOR A SINGLE POINT OF ENTRY AGENCY INCLUDE, BUT ARE NOT LIMITED TO, ALL OF THE FOLLOWING:**

**(A) MAINTAINING ADMINISTRATIVE COSTS THAT ARE REASONABLE, AS DETERMINED BY THE DEPARTMENT OF COMMUNITY HEALTH, IN RELATION TO SPENDING PER CLIENT.**

**(B) IDENTIFYING SAVINGS IN THE ANNUAL STATE MEDICAID BUDGET OR LIMITS IN THE RATE OF GROWTH OF THE ANNUAL STATE MEDICAID BUDGET ATTRIBUTABLE TO PROVIDING SERVICES UNDER SUBSECTION (4) TO CONSUMERS IN NEED OF LONG-TERM CARE SERVICES AND SUPPORTS, TAKING INTO CONSIDERATION MEDICAID CASELOAD AND APPROPRIATIONS.**

**(C) CONSUMER SATISFACTION WITH SERVICES PROVIDED UNDER SUBSECTION (4).**

**(D) TIMELINESS OF DELIVERY OF SERVICES PROVIDED UNDER SUBSECTION (4).**

**(E) QUALITY, ACCESSIBILITY, AND AVAILABILITY OF SERVICES PROVIDED UNDER SUBSECTION (4).**

**(F) COMPLETING AND SUBMITTING REQUIRED REPORTING AND PAPERWORK.**

**(G) NUMBER OF CONSUMERS SERVED.**

**(H) NUMBER AND TYPE OF LONG-TERM CARE SERVICES AND SUPPORTS**

**REFERRALS MADE.**

**(I) NUMBER AND TYPE OF LONG-TERM CARE SERVICES AND SUPPORTS REFERRALS NOT COMPLETED, TAKING INTO CONSIDERATION THE REASONS WHY THE REFERRALS WERE NOT COMPLETED, INCLUDING, BUT NOT LIMITED TO, CONSUMER CHOICE, SERVICES NOT AVAILABLE, CONSUMER FUNCTIONAL OR FINANCIAL INELIGIBILITY, AND FINANCIAL PROHIBITIONS.**

**(8) THE DEPARTMENT OF COMMUNITY HEALTH SHALL DEVELOP STANDARD COST REPORTING METHODS AS A BASIS FOR CONDUCTING COST ANALYSES AND COMPARISONS ACROSS ALL PUBLICLY FUNDED LONG-TERM CARE SYSTEMS AND SHALL REQUIRE SINGLE POINT OF ENTRY AGENCIES TO UTILIZE THESE AND OTHER COMPATIBLE DATA COLLECTION AND REPORTING MECHANISMS.**

**(9) THE DEPARTMENT OF COMMUNITY HEALTH SHALL SOLICIT PROPOSALS FROM ENTITIES SEEKING DESIGNATION AS A SINGLE POINT OF ENTRY AGENCY AND, EXCEPT AS PROVIDED IN SUBSECTION (16) AND SECTION 109J, SHALL INITIALLY DESIGNATE NOT MORE THAN 4 AGENCIES TO SERVE AS A SINGLE POINT OF ENTRY AGENCY IN AT LEAST 4 SEPARATE AREAS OF THE STATE. THERE SHALL NOT BE MORE THAN 1 SINGLE POINT OF ENTRY AGENCY IN EACH DESIGNATED AREA. AN AGENCY DESIGNATED BY THE DEPARTMENT OF COMMUNITY HEALTH UNDER THIS SUBSECTION SHALL SERVE AS A SINGLE POINT OF ENTRY AGENCY FOR AN INITIAL PERIOD OF UP TO 3 YEARS, SUBJECT TO THE PROVISIONS OF SUBSECTION (6). IN ACCORDANCE WITH SUBSECTION (17), THE DEPARTMENT SHALL REQUIRE THAT A CONSUMER RESIDING IN AN AREA SERVED BY A SINGLE POINT OF ENTRY AGENCY DESIGNATED UNDER THIS SUBSECTION UTILIZE THAT AGENCY IF THE CONSUMER IS SEEKING ELIGIBILITY FOR MEDICAID LONG-TERM CARE PROGRAMS.**

**(10) THE DEPARTMENT OF COMMUNITY HEALTH SHALL EVALUATE THE**

**PERFORMANCE OF SINGLE POINT OF ENTRY AGENCIES UNDER THIS SECTION ON AN ANNUAL BASIS.**

**(11) THE DEPARTMENT OF COMMUNITY HEALTH SHALL ENGAGE A QUALIFIED OBJECTIVE INDEPENDENT AGENCY TO CONDUCT A COST-BENEFIT ANALYSIS OF SINGLE POINT OF ENTRY, INCLUDING, BUT NOT LIMITED TO, THE IMPACT ON MEDICAID LONG-TERM CARE COSTS.**

**(12) THE DEPARTMENT OF COMMUNITY HEALTH SHALL MAKE A SUMMARY OF THE ANNUAL EVALUATION, ANY REPORT OR RECOMMENDATION FOR IMPROVEMENT REGARDING THE SINGLE POINT OF ENTRY, AND THE COST-BENEFIT ANALYSIS AVAILABLE TO THE LEGISLATURE AND THE PUBLIC.**

**(13) NOT EARLIER THAN 12 MONTHS AFTER BUT NOT LATER THAN 24 MONTHS AFTER THE IMPLEMENTATION OF THE SINGLE POINT OF ENTRY AGENCY DESIGNATED UNDER SUBSECTION (9), THE DEPARTMENT OF COMMUNITY HEALTH SHALL SUBMIT A WRITTEN REPORT TO THE SENATE AND HOUSE OF REPRESENTATIVES STANDING COMMITTEES DEALING WITH LONG-TERM CARE ISSUES, THE CHAIRS OF THE SENATE AND HOUSE OF REPRESENTATIVES APPROPRIATIONS COMMITTEES, THE CHAIRS OF THE SENATE AND HOUSE OF REPRESENTATIVES APPROPRIATIONS SUBCOMMITTEES ON COMMUNITY HEALTH, AND THE SENATE AND HOUSE FISCAL AGENCIES REGARDING THE ARRAY OF SERVICES PROVIDED BY THE DESIGNATED SINGLE POINT OF ENTRY AGENCIES AND THE COST, EFFICIENCIES, AND EFFECTIVENESS OF SINGLE POINT OF ENTRY. IN THE REPORT REQUIRED UNDER THIS SUBSECTION, THE DEPARTMENT OF COMMUNITY HEALTH SHALL PROVIDE RECOMMENDATIONS REGARDING THE CONTINUATION, CHANGES, OR CANCELLATION OF SINGLE POINT OF ENTRY AGENCIES BASED ON DATA PROVIDED UNDER SUBSECTIONS (4) AND (10) TO (12).**

**(14) BEGINNING IN THE YEAR THE REPORT IS SUBMITTED AND**

**ANNUALLY AFTER THAT, THE DEPARTMENT OF COMMUNITY HEALTH SHALL MAKE A PRESENTATION ON THE STATUS OF SINGLE POINT OF ENTRY AND ON THE SUMMARY INFORMATION AND RECOMMENDATIONS REQUIRED UNDER SUBSECTION (12) TO THE SENATE AND HOUSE OF REPRESENTATIVES APPROPRIATIONS SUBCOMMITTEES ON COMMUNITY HEALTH TO ENSURE THAT LEGISLATIVE REVIEW OF SINGLE POINT OF ENTRY SHALL BE PART OF THE ANNUAL STATE BUDGET DEVELOPMENT PROCESS.**

**(15) THE DEPARTMENT OF COMMUNITY HEALTH SHALL PROMULGATE RULES TO IMPLEMENT THIS SECTION NOT LATER THAN 270 DAYS AFTER SUBMITTING THE REPORT REQUIRED IN SUBSECTION (13).**

**(16) THE DEPARTMENT OF COMMUNITY HEALTH SHALL NOT DESIGNATE MORE THAN THE INITIAL 4 AGENCIES DESIGNATED UNDER SUBSECTION (9) TO SERVE AS SINGLE POINT OF ENTRY AGENCIES OR AGENCIES SIMILAR TO SINGLE POINT OF ENTRY AGENCIES UNLESS ALL OF THE FOLLOWING OCCUR:**

**(A) THE WRITTEN REPORT IS SUBMITTED AS PROVIDED UNDER SUBSECTION (13).**

**(B) TWELVE MONTHS HAVE PASSED SINCE THE SUBMISSION OF THE WRITTEN REPORT REQUIRED UNDER SUBSECTION (13).**

**(C) THE LEGISLATURE APPROPRIATES FUNDS TO SUPPORT THE DESIGNATION OF ADDITIONAL SINGLE POINT OF ENTRY AGENCIES.**

**(17) A SINGLE POINT OF ENTRY AGENCY FOR LONG-TERM CARE SHALL SERVE AS THE SOLE AGENCY WITHIN THE DESIGNATED SINGLE POINT OF ENTRY AREA TO ASSESS A CONSUMER'S ELIGIBILITY FOR MEDICAID LONG-TERM CARE PROGRAMS UTILIZING A COMPREHENSIVE LEVEL OF CARE ASSESSMENT APPROVED BY THE DEPARTMENT OF COMMUNITY HEALTH.**

**(18) ALTHOUGH A COMMUNITY MENTAL HEALTH SERVICES PROGRAM MAY SERVE AS A SINGLE POINT OF ENTRY AGENCY TO PROVIDE SERVICES TO**

House Bill No. 5389 (H-3) as amended September 19, 2006

**INDIVIDUALS WITH MENTAL ILLNESS OR DEVELOPMENTAL DISABILITY, COMMUNITY MENTAL HEALTH SERVICES PROGRAMS ARE NOT SUBJECT TO THE PROVISIONS OF THIS ACT.**

**[(19) MEDICAID REIMBURSEMENT FOR HEALTH FACILITIES OR AGENCIES SHALL NOT BE REDUCED BELOW THE LEVEL OF RATES AND PAYMENTS IN EFFECT ON OCTOBER 1, 2006, AS A DIRECT RESULT OF THE 4 PILOT SINGLE POINT OF ENTRY AGENCIES DESIGNATED UNDER SUBSECTION (9).**

**(20)] FOR THE PURPOSES OF THIS SECTION:**

**(A) "ADMINISTRATIVE COSTS" MEANS THE COSTS THAT ARE USED TO PAY FOR EMPLOYEE SALARIES NOT DIRECTLY RELATED TO CARE PLANNING AND SUPPORTS COORDINATION AND ADMINISTRATIVE EXPENSES NECESSARY TO OPERATE EACH SINGLE POINT OF ENTRY AGENCY.**

**(B) "ADMINISTRATIVE EXPENSES" MEANS THE COSTS ASSOCIATED WITH THE FOLLOWING GENERAL ADMINISTRATIVE FUNCTIONS:**

**(*i*) FINANCIAL MANAGEMENT, INCLUDING, BUT NOT LIMITED TO, ACCOUNTING, BUDGETING, AND AUDIT PREPARATION AND RESPONSE.**

**(*ii*) PERSONNEL MANAGEMENT AND PAYROLL ADMINISTRATION.**

**(*iii*) PURCHASE OF GOODS AND SERVICES REQUIRED FOR ADMINISTRATIVE ACTIVITIES OF THE SINGLE POINT OF ENTRY AGENCY, INCLUDING, BUT NOT LIMITED TO, THE FOLLOWING GOODS AND SERVICES:**

**(A) UTILITIES.**

**(B) OFFICE SUPPLIES AND EQUIPMENT.**

**(C) INFORMATION TECHNOLOGY.**

**(D) DATA REPORTING SYSTEMS.**

**(E) POSTAGE.**

**(F) MORTGAGE, RENT, LEASE, AND MAINTENANCE OF BUILDING AND OFFICE SPACE.**

**(G) TRAVEL COSTS NOT DIRECTLY RELATED TO CONSUMER SERVICES.**

**(H) ROUTINE LEGAL COSTS RELATED TO THE OPERATION OF THE SINGLE POINT OF ENTRY AGENCY.**

**(C) "AUTHORIZED REPRESENTATIVE" MEANS A PERSON EMPOWERED BY**

**THE CONSUMER BY WRITTEN AUTHORIZATION TO ACT ON THE CONSUMER'S BEHALF TO WORK WITH THE SINGLE POINT OF ENTRY, IN ACCORDANCE WITH THIS ACT.**

**(D) "GUARDIAN" MEANS AN INDIVIDUAL WHO IS APPOINTED UNDER SECTION 5306 OF THE ESTATES AND PROTECTED INDIVIDUALS CODE, 1998 PA 386, MCL 700.5306. GUARDIAN INCLUDES AN INDIVIDUAL WHO IS APPOINTED AS THE GUARDIAN OF A MINOR UNDER SECTION 5202 OR 5204 OF THE ESTATES AND PROTECTED INDIVIDUALS CODE, 1998 PA 386, MCL 700.5202 AND 700.5204, OR WHO IS APPOINTED AS A GUARDIAN UNDER THE MENTAL HEALTH CODE, 1974 PA 258, MCL 300.1001 TO 300.2106.**

**(E) "INFORMED CHOICE" MEANS THAT THE CONSUMER IS PRESENTED WITH COMPLETE AND UNBIASED INFORMATION ON HIS OR HER LONG-TERM CARE OPTIONS, INCLUDING, BUT NOT LIMITED TO, THE BENEFITS, SHORTCOMINGS, AND POTENTIAL CONSEQUENCES OF THOSE OPTIONS, UPON WHICH HE OR SHE CAN BASE HIS OR HER DECISION.**

**(F) "PERSON-CENTERED PLANNING" MEANS A PROCESS FOR PLANNING AND SUPPORTING THE CONSUMER RECEIVING SERVICES THAT BUILDS ON THE INDIVIDUAL’S CAPACITY TO ENGAGE IN ACTIVITIES THAT PROMOTE COMMUNITY LIFE AND THAT HONORS THE CONSUMER’S PREFERENCES, CHOICES, AND ABILITIES. THE PERSON-CENTERED PLANNING PROCESS INVOLVES FAMILIES, FRIENDS, AND PROFESSIONALS AS THE CONSUMER DESIRES OR REQUIRES.**

**(G) "SINGLE POINT OF ENTRY" MEANS A PROGRAM FROM WHICH A CURRENT OR POTENTIAL LONG-TERM CARE CONSUMER CAN OBTAIN LONG-TERM CARE INFORMATION, SCREENING, ASSESSMENT OF NEED, CARE PLANNING, SUPPORTS COORDINATION, AND REFERRAL TO APPROPRIATE LONG-TERM CARE SUPPORTS AND SERVICES.**

**(H) "SINGLE POINT OF ENTRY AGENCY" MEANS THE ORGANIZATION DESIGNATED BY THE DEPARTMENT OF COMMUNITY HEALTH TO PROVIDE CASE MANAGEMENT FUNCTIONS FOR CONSUMERS IN NEED OF LONG-TERM CARE SERVICES WITHIN A DESIGNATED SINGLE POINT OF ENTRY AREA.**

**SEC. 109J. THE DEPARTMENT OF COMMUNITY HEALTH SHALL NOT DESIGNATE MORE THAN THE INITIAL 4 AGENCIES DESIGNATED UNDER SECTION 109I(9) TO SERVE AS SINGLE POINT OF ENTRY AGENCIES OR AGENCIES SIMILAR TO SINGLE POINT OF ENTRY AGENCIES UNLESS THE CONDITIONS OF SECTION 109I(16) ARE MET AND THE LEGISLATURE REPEALS THIS SECTION.**

Amendment No. 2a
September 19, 2006

**House Bill No. 5389** 2a

Rep. Shaffer moved to amend the bill as follows:

1. Amend page 12, following line 3, by inserting:

**"(19) MEDICAID REIMBURSEMENT FOR HEALTH FACILITIES OR AGENCIES SHALL NOT BE REDUCED BELOW THE LEVEL OF RATES AND PAYMENTS IN EFFECT ON OCTOBER 1, 2006, AS A DIRECT RESULT OF THE 4 PILOT SINGLE POINT OF ENTRY AGENCIES DESIGNATED UNDER SUBSECTION (9).**" and renumbering the remaining subsection.

**SUBSTITUTE FOR**

**HOUSE BILL NO. 6478**

A bill to amend 1939 PA 280, entitled

"The social welfare act,"

by amending sections 112b, 112c, and 112e (MCL 400.112b, 400.112c, and 400.112e), as added by 1995 PA 85; and to repeal acts and parts of acts.

**THE PEOPLE OF THE STATE OF MICHIGAN ENACT:**

Sec. 112b. As used in this section and sections 112c to 112e:

~~(a) "Home health care" means care described in section 109c.~~

**(A) "ASSET DISREGARD" MEANS, WITH REGARD TO THE STATE'S MEDICAL ASSISTANCE PROGRAM, DISREGARDING ANY ASSETS OR RESOURCES IN AN AMOUNT EQUAL TO THE INSURANCE BENEFIT PAYMENTS THAT ARE MADE TO OR ON BEHALF OF AN INDIVIDUAL WHO IS A BENEFICIARY UNDER A QUALIFIED LONG-TERM CARE INSURANCE PARTNERSHIP POLICY.**

(b) "Long-term care insurance policy" means a policy described in chapter 39 of the insurance code of 1956, ~~Act No. 218 of the Public Acts of 1956, being sections 500.3901 to 500.3955 of the Michigan Compiled Laws~~ **1956 PA 218, MCL 500.3901 TO 500.3955**.

**(C) "LONG-TERM CARE PARTNERSHIP PROGRAM" MEANS A QUALIFIED STATE LONG-TERM CARE INSURANCE PARTNERSHIP AS DEFINED IN SECTION 1917(B) OF THE SOCIAL SECURITY ACT, 42 USC 1396P.**

**(D) "LONG-TERM CARE PARTNERSHIP PROGRAM POLICY" MEANS A QUALIFIED LONG-TERM CARE INSURANCE POLICY THAT THE COMMISSIONER OF THE OFFICE OF FINANCIAL AND INSURANCE SERVICES CERTIFIES AS MEETING THE REQUIREMENTS OF SECTION 1917(B) OF THE SOCIAL SECURITY ACT, 42 USC 1396P, SECTION 6021 OF THE FEDERAL DEFICIT REDUCTION ACT OF 2005, PUBLIC LAW 109-171, AND ANY APPLICABLE FEDERAL REGULATIONS OR GUIDELINES.**

**(E)** ~~(c)~~ "Medicaid" means the program of medical assistance established by the department **OF COMMUNITY HEALTH** under section 105.

~~(d) "Nursing home care" means nursing home services as described in section 109(1)(c).~~

~~(e) "Partnership policy" means a long-term care insurance policy that meets the requirements set forth in section 112d.~~

~~(f) "Partnership program" means the Michigan partnership for long-term care program established under section 112c.~~

Sec. 112c. (1) Subject to subsection ~~(4)~~ **(5)**, the department **OF COMMUNITY HEALTH IN CONJUNCTION WITH THE OFFICE OF FINANCIAL AND INSURANCE SERVICES AND THE DEPARTMENT OF HUMAN SERVICES** shall establish ~~the Michigan partnership for long-term care program~~ **A**

**LONG-TERM CARE PARTNERSHIP PROGRAM IN MICHIGAN** to provide for the financing of long-term care through a combination of private insurance and medicaid. **IT IS THE INTENT OF THE LONG-TERM CARE PARTNERSHIP PROGRAM TO DO ALL OF THE FOLLOWING:**

**(A) PROVIDE INCENTIVES FOR INDIVIDUALS TO INSURE AGAINST THE COSTS OF PROVIDING FOR THEIR LONG-TERM CARE NEEDS.**

**(B) PROVIDE A MECHANISM FOR INDIVIDUALS TO QUALIFY FOR COVERAGE OF THE COST OF THEIR LONG-TERM CARE NEEDS UNDER MEDICAID WITHOUT FIRST BEING REQUIRED TO SUBSTANTIALLY EXHAUST THEIR RESOURCES.**

**(C) ALLEVIATE THE FINANCIAL BURDEN ON THE STATE'S MEDICAL ASSISTANCE PROGRAM BY ENCOURAGING THE PURSUIT OF PRIVATE INITIATIVES.**

~~(2) An individual is eligible to participate in the partnership program if he or she meets all of the following requirements:~~

~~(a) Is a Michigan resident.~~

~~(b) Purchases a partnership policy that is delivered, issued for delivery, or renewed on or after the effective date of this section, and maintains the partnership policy in effect throughout the period of participation in the partnership program.~~

~~(c) Exhausts the minimum benefits under the partnership policy as described in section 112d(1)(a). Benefits received under a long-term care insurance policy before the effective date of this section do not count toward the exhaustion of benefits required in this subdivision.~~

~~(3) Upon application of an individual who meets the~~

~~requirements described in subsection (2), the department shall determine the individual's eligibility for medicaid in accordance with both of the following:~~

~~(a) After disregarding financial assets exempted under medicaid eligibility requirements, the department shall disregard an additional amount of financial assets equal to the dollar amount of coverage under the partnership policy.~~

~~(b) The department shall consider the individual's income in accordance with medicaid eligibility requirements.~~

~~(4) The department shall seek appropriate amendments to the medicaid state plan and shall apply for any necessary waiver of medicaid requirements by the federal health care financing administration to implement the partnership program.~~

~~(5) The department shall not implement the partnership program unless both of the following apply:~~

~~(a) A federal waiver of medicaid requirements is obtained, if necessary.~~

~~(b) Federal law exempts individuals who receive medicaid under this section from estate recovery requirements under section 1917 of title XIX of the social security act, 42 U.S.C. 1396p.~~

**(2) AN INDIVIDUAL WHO IS A BENEFICIARY OF A MICHIGAN LONG-TERM CARE PARTNERSHIP PROGRAM POLICY IS ELIGIBLE FOR ASSISTANCE UNDER THE STATE'S MEDICAL ASSISTANCE PROGRAM USING THE ASSET DISREGARD AS PROVIDED UNDER SUBSECTION (5).**

**(3) THE DEPARTMENT OF COMMUNITY HEALTH SHALL PURSUE RECIPROCAL AGREEMENTS WITH OTHER STATES TO EXTEND THE ASSET DISREGARD TO MICHIGAN RESIDENTS WHO PURCHASED LONG-TERM CARE PARTNERSHIP**

**POLICIES IN OTHER STATES THAT ARE COMPLIANT WITH TITLE VI, SECTION 6021 OF THE FEDERAL DEFICIT REDUCTION ACT OF 2005, PUBLIC LAW 109-171, AND ANY APPLICABLE FEDERAL REGULATIONS OR GUIDELINES.**

**(4) UPON DIMINISHMENT OF ASSETS BELOW THE ANTICIPATED REMAINING BENEFITS UNDER A LONG-TERM CARE PARTNERSHIP PROGRAM POLICY, CERTAIN ASSETS OF AN INDIVIDUAL, AS PROVIDED UNDER SUBSECTION (5), SHALL NOT BE CONSIDERED WHEN DETERMINING ANY OF THE FOLLOWING:**

**(A) MEDICAID ELIGIBILITY.**

**(B) THE AMOUNT OF ANY MEDICAID PAYMENT.**

**(C) ANY SUBSEQUENT RECOVERY BY THE STATE OF A PAYMENT FOR MEDICAL SERVICES OR LONG-TERM CARE SERVICES.**

**(5) NOT LATER THAN 180 DAYS AFTER THE EFFECTIVE DATE OF THE AMENDATORY ACT THAT ADDED THIS SUBSECTION, THE DEPARTMENT OF COMMUNITY HEALTH SHALL APPLY TO THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES FOR AN AMENDMENT TO THE STATE'S MEDICAID STATE PLAN TO ESTABLISH THAT THE ASSETS AN INDIVIDUAL OWNS AND MAY RETAIN UNDER MEDICAID AND STILL QUALIFY FOR BENEFITS UNDER MEDICAID AT THE TIME THE INDIVIDUAL APPLIES FOR BENEFITS IS INCREASED DOLLAR-FOR-DOLLAR FOR EACH DOLLAR PAID OUT UNDER THE INDIVIDUAL'S LONG-TERM CARE INSURANCE POLICY IF THE INDIVIDUAL IS A BENEFICIARY OF A QUALIFIED LONG-TERM CARE PARTNERSHIP PROGRAM POLICY.**

**(6) IF THE LONG-TERM CARE PARTNERSHIP PROGRAM IS DISCONTINUED, AN INDIVIDUAL WHO PURCHASED A MICHIGAN LONG-TERM CARE PARTNERSHIP PROGRAM POLICY BEFORE THE DATE THE PROGRAM WAS DISCONTINUED SHALL BE ELIGIBLE TO RECEIVE ASSET DISREGARD IF ALLOWED AS PROVIDED BY TITLE VI, SECTION 6021 OF THE FEDERAL DEFICIT REDUCTION ACT OF**

**2005, PUBLIC LAW 109-171.**

**(7) THE DEPARTMENT OF COMMUNITY HEALTH SHALL CONTRACT WITH THE MICHIGAN MEDICARE MEDICAID ASSISTANCE PROGRAM TO PROVIDE COUNSELING SERVICES UNDER THE MICHIGAN LONG-TERM CARE PARTNERSHIP PROGRAM.**

**(8) THE DEPARTMENT OF COMMUNITY HEALTH, IN CONSULTATION WITH THE OFFICE OF FINANCIAL AND INSURANCE SERVICES, SHALL DEVELOP A NOTICE TO CONSUMERS DETAILING IN PLAIN LANGUAGE THE PERTINENT PROVISIONS OF QUALIFIED STATE LONG-TERM CARE INSURANCE PARTNERSHIP POLICIES AS THEY RELATE TO MEDICAID ELIGIBILITY AND SHALL DETERMINE THE APPROPRIATE DISTRIBUTION OF THE NOTICE. THE NOTICE SHALL BE AVAILABLE IN A PRINTABLE FORM ON THE OFFICE OF FINANCIAL AND INSURANCE SERVICES'S WEBSITE.**

**(9) THE DEPARTMENT, THE DEPARTMENT OF COMMUNITY HEALTH, AND THE OFFICE OF FINANCIAL AND INSURANCE SERVICES SHALL POST, ON THEIR RESPECTIVE WEBSITES, INFORMATION ON HOW TO ACCESS THE NATIONAL CLEARINGHOUSE ESTABLISHED UNDER THE FEDERAL DEFICIT REDUCTION ACT OF 2005, PUBLIC LAW 109-171, WHEN THE NATIONAL CLEARINGHOUSE BECOMES AVAILABLE TO CONSUMERS.**

Sec. 112e. The department **OF COMMUNITY HEALTH** may promulgate rules pursuant to the administrative procedures act of 1969, ~~Act No. 306 of the Public Acts of 1969, being sections 24.201 to 24.328 of the Michigan Compiled Laws~~ **1969 PA 306, MCL 24.201 TO 24.328**, as necessary to implement the partnership program **IN ACCORDANCE WITH THE REQUIREMENTS OF SECTION 1917(B) OF THE SOCIAL SECURITY ACT, 42 USC 1396P, SECTION 6021 OF THE FEDERAL DEFICIT REDUCTION ACT OF 2005, PUBLIC LAW 109-171, AND APPLICABLE FEDERAL REGULATIONS OR GUIDELINES**.

Enacting section 1. Section 112d of the social welfare act, 1939 PA 280, MCL 400.112d, is repealed.

LTC Conference 2007
08-23-06

SESSIONS

- Grants:
  - Single Points of Entry/Aging and Disability Resource Centers -
  - Self-Determination in Long-Term Care
  - Promoting the Employment of Persons with Disabilities
  - Options for Managed Long-Term Care
  - Background Checks and Training for a Better Workforce

- Direct Care Worker Issues
  - Apprenticeships: It is Not Just for Electricians and Plumbers
  - Support the Family Caregivers
  - Regional Skills Alliance – partnerships for Workforce Solutions
  - Michigan Quality Community Care Council
  - Healthcare Coverage for Caregivers
  - CNA Curriculum: The Road to Improvement

- Consumer Issues
  - Coordinated Advocacy
  - Choosing from the Array of LTC Supports and Services
  - Maintaining and Achieving Legal Autonomy
  - Person-Centered Planning 101
  - Coaching Supervision for Consumers and Others
  - Advocacy 101: Crafting Your Message and Using it in Grassroots Advocacy
  - The Consumer Voice in Quality Management
  - Forming and Supporting a Local Advocacy Action Group
  - Family Councils as Agents of Change
  - Consumer Cooperative; From Individual to Organizational Control
  - Know Your Rights and How to Protect Them

- Policy Issues
  - Principles for System Reform
  - Michigan's Direction in Long-Term Care
  - Recent Federal Initiatives to Support Responsive LTC Systems
  - State Leadership for Long-Term Care
  - The Role of the Public Mental Health System in LTC
  - Who Uses Medicaid LTC Services: A Look at the Data
  - Medicaid Long Term Care Task Force: Where Are We Now?
  - LTC Commission
  - State Models
  - The Faces of Medicaid
  - Facing the Future – Understanding the Growing Challenge of Long-Term Care

    - Working Together for a Better LTC System
    - Other State Achievements in LTC Reform
    - Planning to Pay for Long-Term Care
    - Healthcare Providers Collaborate for Better Outcomes

- Nursing Home Issues
    - The Future of Residential Care
    - Defining and Achieving Quality
    - MIChoice Waiver – Amendments to the Waiver
    - State Initiatives in Nursing Facilities Transition
    - Changing the Culture of Residential Programs
    - Solving the Panic of Finding LTC When a Hospital Stay is Ending
    - Transitioning to Home: Assisting Nursing Facility Residents to Plan and Accomplish A Move to Independence

- Programs
    - Michigan Model for Services for Persons with Traumatic Brain Injury
    - Palliative Care: An Array of Support and Comfort Care
    - Telemedicine: Bringing Technology Home
    - Working Together to Provide Quality End of Life Care
    - Designing Livable Communities
    - Greater Independence Through Assistive Technology
    - Growing Numbers, Growing Needs: Dementia Care in the 21st Century

CRACKER BARREL: Focused discussions designated of specific topics, hosted by a topic expert and facilitator. These will be offered in lieu of a formal workshop. The suggested topics are:

- Applied PCP – Practical Issues
- Other States Achievements in Long-Term Care Reform
- Thinking Outside the Box: Planning for LTC

ROUND TABLE DISCUSSIONS: Informal discussions during breakfast hosted by a facilitator. During breakfast. The suggested topics are:

- Self Determination
- Quality in the MIChoice Waiver
- Direct Care Worker Issues
- SPE/ADRC
- The Future of Residential Care
- Elder Abuse in Community and Residential Settings
- The Ups and Downs of Reverse Mortgages, Annuities and Long-Term Care Insurance
- Tax Credits for Caregivers

- Michigan Quality Community Care Council
- Employment for Persons with Disabilities

RESOURCE ROOM:  Hands-on capabilities

- Internet access to nursing home quality reports
- Background Checks
- Assistive Technology

# DRAFT Progress Report on Task Force Recommendations

**Prepared 9.18.06**

**<u>Recommendation # 8 Workforce Development:</u> Michigan Should Build and Sustain Culturally Competent, Highly Valued, Competitively Compensated, and Knowledgeable LTC Workforce Teams that Provide High Quality Care within a Supportive Environment and are Responsive to Consumer Needs and Choices. Pages 21-22 of the Final Report of the Task Force.**

| *Recommendations* for State Activities from the Task Force | Progress of state agencies and policies | Next Steps for OLTCSS Commission | Timeframe |
|---|---|---|---|
| 1. Develop within the Michigan Works! Agencies (MWA) network, recruitment and screening protocols and campaigns that meet the needs of employers and job seekers. | Several MWAs through either their Regional Skills Alliances (RSAs) or federal grants are exploring new uses of WorkKeys or new assessment tools, JobFit. | | |
| 2. Recast the state's Work First program to recruit, screen, train, and support individuals who demonstrate the desire, abilities, and commitment to work in LTC settings. | State (DHS and DLEG) is piloting new JET (Jobs, Education, & Training) program to replace Work First in four locations for 18 months. Connection to LTC sector unclear. For more info: http://www.michigan.gov/cis/0,1607,7-154-41500---,00.html | | |
| 3. Develop recruitment campaigns to attract men, older workers, people of diverse cultural backgrounds, and people with disabilities to long-term care | No progress identified. | | |

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| careers. | | | |
| 4. Mobilize state agencies' activities to include the research, exploration, explanation, and promotion of career opportunities in long-term care. | Some RSAs have created information on health care careers generally.<br><br>DCH, DLEG, and DHS have agreed to create a general health care workforce center. | | |
| 5. Improve and increase training opportunities for direct care workers (DCW) to allow for enhanced skill development and employability. | With federal grant, training in adult abuse and neglect prevention is being offered to 11,000 workers who have "direct access" to LTC consumers or their financial information. To be completed in 9/2007.<br><br>With federal grant, some home help providers are receiving training in dementia care.<br><br>Traverse City based RSA is offering another round of dementia, body mechanics, and other 4 hours courses to DCWs in their 13 county service area. | | |
| 6. Increase training opportunities for employers to improve supervision and create a positive work environment. | DCH has funded a round of training to build the capacities of CMHs to aide consumers who want to use consumer directed supports and be the direct "supervisor" of staff. | | |
| 7. Reduce the rates of injury and exposure to hazardous materials to protect the current workforce and encourage new workers to join this workforce because of the sector's safety record. | MiOSHA did outreach to LTC stakeholders to explain the MiOSHA offered grants for safety training. Unclear if any LTC specific trainings were funded or the applicability of funded trainings to LTC. | | |

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| 8. Raise Medicaid reimbursement rates and other incentives so that the LTC workforce receives compensation necessary to receive quality care as defined by the consumer. | Legislature and Governor approved:<br>A. Home Help providers' salary rates to increase on 10/1/06 to a floor of $7.00 per hour and other county wage rates that are already above $7.00 to increase by $0.50 per hour.<br>B. A 2% increase to CMH boards for wage increase of DCWs in 2007.<br>C. State earned income tax credit (EITC) for 2008 tax year. | | |
| 9. Expand the ability of all long-term care employers and their employees, particularly their part-time employees, to access affordable health care coverage for themselves and their families. | Work of federally funded State Planning Grant for the Uninsured completed. Recommends health care coverage for all Michigan residents.<br><br>DCH is negotiating with federal government for a waiver to cover 550,000 uninsured residents whose income is below 200% of poverty. Michigan First Health Plan intends to offer a health insurance product. | | |
| 9.1 State agencies should work collaboratively to identify standards and benchmarks ensuring that direct care workers are key partners and team members in providing quality care and supports. | No progress identified. | | |
| 10. Develop health professional | DCH has a proposal developed in conjunction with one RSA (Michigan Direct Care | | |

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| curricula and reform current practice patterns to reflect the changing needs of the population. Recognize the unique needs of the elderly; people with chronic health problems; people approaching end-of-life; people of all ages with disabilities; and those in need of rehabilitative and restorative services across LTC and acute care settings. | Workforce Initiative) to "revised" the state's Michigan Model curriculum to remove obsolete references (mercury thermometer, etc) from the training that must be taken to prepare to be a certified nursing assistant (CNA) in the state's Medicaid certified nursing homes.<br><br>The same group is exploring enhancing the CNA curriculum beyond the 75 hour minimum and the federal minimums for approving "trainers" and "programs." | | |
| 11. LTC administration will track employment trends, including turnover rates. | No progress identified. | | |

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| ***Benchmarks*** to measure State Activities from the Task Force | Progress of State Agencies and Policies | Next Steps for OLTCSS Commission | Timeframe |
| A. Measurable increase in LTC employer use of MWA services and in LTC employer hiring of Work First participants. | No progress identified. Not clear that system has capacity to track or measure change. | | |
| B. More qualified Work First participants are recruited and successfully employed in the LTC industry, while continuing their education for entry into licensed occupations. | No progress identified. Not clear that system has capacity to track or measure change. | | |
| C. Higher compensation packages and increased training opportunities. | Compensation:<br>Higher salaries, moving from a floor of $5.15 an hour to $7.00 and higher, for 45,000+ Home Help providers.<br><br>Increased state funding earmarked for compensation for DCWs associated with CMHs.<br><br>Training:<br>2,000+ direct access staff trained in abuse and neglect prevention. | | |

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| | Several 100 DCWs in Traverse City area trained with MWA funding. | | |
| D. Continuously and incrementally reduced turnover rates over the next decade. | No progress identified. System does not appear to have the capacity to track or measure change across the array of services. | | |
| E. All people working in LTC have access to affordable health care coverage. | No new coverage opportunities created. | | |
| F. Increased use of creative management and workplace practices. | DCH sponsored Facility Innovations Design Supplemental (FIDS) program has recruited as many as 75 Medicaid funded nursing homes to remodel or replace their facilities and to implement "culture change" activities over three years. | | |
| G. Use of data and consumer satisfaction to inform a system of services, state policies, and employer practices that result in consumer-driven outcomes. | No progress identified but see other sections of the recommendations. | | |
| H. Increased opportunities and incentives for LTC employers and their supervisory personnel to | See # 6 above. Progress limited to consumers who are supervising directly through consumer directed services. | | |

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| improve supervisory and leadership skills to create positive workplace environments and relationships to reduce turnover. | Also, see F above and the "culture change" possibilities in FIDS nursing homes. | | |

# Single Point of Entry Demonstration Projects
# Contact Information

## Detroit SPE

*Serves the Cities of Detroit, Grosse Pointe (GP), GP Farms, GP Park, GP Shores, GP Woods, Hamtramck, Harper Woods, Highland Park*

Sponsor:
Detroit Area Agency on Aging

Contact:
Earlene Traylor Neal
313-446-4444

## Southwest Michigan SPE

*Serves Barry, Berrien, Branch, Calhoun, Cass, Kalamazoo, St. Joseph, and Van Buren counties*

Sponsors:
Region 3-A Area Agency on Aging, Kalamazoo
Region 3-B Area Agency on Aging, Battle Creek
Region 3-C Area Agency on Aging, Coldwater
Region IV Area Agency on Aging, St. Joseph

Contact:
John Altena
269-983-0177

## West Michigan SPE

*Serves Allegan, Ionia, Kent, Lake, Mason, Mecosta, Montcalm, Muskegon, Newaygo, Oceana, Osceola and Ottawa counties*

Sponsors:
AAA of Western Michigan, Grand Rapids
HHS, Inc., Grand Rapids
Senior Resources, Muskegon Heights

Contact:
Chuck Logie
616-456-5664

## Upper Peninsula SPE

*Serves Alger, Baraga, Chippewa, Delta, Dickinson, Gogebic, Houghton, Iron, Keweenaw, Luce, Mackinac, Marquette, Menominee, Ontonagon, and Schoolcraft counties*

Sponsor:
U.P. Commission for Area Progress, Escanaba

Contact:
Mark Bomberg
906-786-4701

**ADRC/SPE Evaluation** **A Conceptual Approach**

## Introduction

This document addresses content, process, and decision points needed to develop an evaluation plan. There are several issues that are of concern. First, the need to build a process that can be accomplished quickly but allows maximum input from consumers and advocates. Second, we hope to involve a professional evaluator to help develop the details and assure their expertise in the design. Third, the evaluation efforts need to be integrated with the other work groups and with the overall quality assurance efforts.

Development factors:

- Primary audience for the evaluation
- Identify goals
- Method(s) to measure
- Performance Indicators and Data elements

## Primary audience

- LTC Advisory Commission (LTC recommendations)
- Legislature
- MDCH
- AoA/CMS

The presence of multiple audiences makes goal selection more difficult. While there is some overlap there are different priorities among the various stakeholders. Goals for the ADRC grant are most clearly laid out, but they don't address all of the needs. The LTC recommendations are not written in an outcome/goal framework. The Legislature has chosen indicators but not listed outcomes. MDCH needs to meet contract oversight requirements and good public policy.

During the past months, the Office has worked with various lists of goals, performance indicators, and data elements. We need to establish a process for sharing draft goals, soliciting input, prioritizing goals, identifying performance indicators for the chosen goals and then identify data sources and elements to measure. The following represents a starting point for brainstorming and prioritization.

## Goals

1) Awareness/Visibility,

ADRC/SPE are viewed as trusted source of information
Consumers are knowledgeable of service options
Providers know scope of SPE functions

2) Consumer Focus

Information is objective and consumers know implications of various choices
Consumers demonstrate understanding of available resources and options,
Consumers make informed decisions
Information is reliable
Consumers have a voice in program design
Increased consumer advocacy

3) Access

Consumers locate services appropriate to their need
There is a decrease in unnecessary institutionalization,
Increased private pay options are available
Consumers receive services that are of high quality

4) Efficiency

Service access is integrated—seamless
Consumer report ease and timeliness of assistance
Provider stakeholders report ease and timeliness of assistance
Collaboration occurs between providers
Consumers report satisfaction with referral system
Consumers experience ease of navigation between services

5) Effectiveness

Consumers receive services that meet their preferences
Referrals are followed through on
Satisfaction among stakeholders
Consumer voice in evaluation

**ADRC work plan goals:**

- Create a management system that supports the implementation of ADRC/SPEs. (1-5)
- Create templates for the pilot SPE that can be modified, as experience dictates, for future statewide expansion (1-5)
- Improve access to publicly funded services and supports by streamlining financial eligibility and consolidating functional assessment processes. (4)
- Reduce unnecessary institutionalization through diversion and transition services (3,5)
- Information technology supports both ADRC/SPE business requirements and consumer need for timely and accurate resource information. (1-5)

- Enable ADRC/SPE to redirect and/or adjust program development effort based on formative learning obtained through ongoing evaluation. (1-5)

**SPE contract goals (indicators)**

- General support plans will demonstrate objectivity and lack of bias (2)
- Records on audit will demonstrate adherence to mutually agreed upon principles for person-centered thinking (2)
- Consumer appeals and complain resolutions will follow approved process and timeliness indicators (2)
- Records reviewed will demonstrate functional eligibility based upon the nursing facility level of care definition for nursing facilities, MI Choice Program and Programs of All Inclusive Care of the Elderly as developed (4)
- Consumers known to be seeking transition services will be assessed with in the first twelve months of the project (3)
- Required collaborators will report effective and productive relationships with the SPE agency. (4)
- I/A and Options counseling activities will meet or exceed established time frames (4, 5 )
- Consumers will report receiving sufficient information to make long term care choices to their satisfaction (1,2)
- Community referral agencies will report knowledge of SPE functions and methods for contact (1)

**Goals from draft legislation**

- The number of referrals by level of care setting. ( 3/4/5)
- The number of cases in which the care setting chosen by the consumer resulted in costs exceeding the costs that would have been incurred had the consumer chosen to receive care in a nursing home. (3/4)
- The number of cases in which admission to a long-term care facility was denied and the reasons for denial. (3/4/5)
- The number of cases in which a memorandum of understanding was required. (4/5)
- The rates and causes of hospitalization.
- The rates of nursing home admissions. (3/4/5)
- The number of consumers transitioned out of a nursing home. (3/4/5)
- The average time frame for case management review. (3/4)
- The total number of contacts and consumers served. (1/3/4/5)
- The data necessary for completion of the cost-benefit analysis required under subsection 11.
- The number and types of referrals made. (1-5)
- The number and types of referrals that were not able to be made and the reasons why the referrals were not completed, including, but not limited to, consumer choice, services not available, consumer functional or financial ineligibility, and financial prohibitions. (1-5)

**Goals from overview document**

- The public view the SPE/ADRC as a trusted source of complete and unbiased information (1, 2)
- Information is comprehensive and readily available. (2,3)
- Increased numbers of persons have information they need to make a long term care choices; (1,2,3)
- SPE/ADRC services are available at hospitals and other critical locations; (1,4)
- Access is streamlined. Timeliness for financial eligibility determinations meets (or exceeds) federal standard of promptness (4)
- Persons wishing to transition between long term care settings have assistance; (4)
- Increased numbers of persons who wish to and who use long term care support services maintain connections with family, neighbors, and friends; (2)
- Persons with disabilities and frail older adults utilize preventive health activities; (2)
- Service decisions are consumer driven (2, 5)
- Consumers have a defined role in determining quality and prioritizing initiatives (2,5)
- Caregivers are involved and supported by the formal service system. (2,5)

**Method(s) to measure**

- Service Point and automated reports
- Customer surveys and follow-up
- Stakeholder survey/focus group
- Public Awareness survey if available
- SART report
- Contract management tool
- Utilization data from Medicaid and DHS
- SPE reports to MDCH

# Michigan Department of Community Health
# Office of Long-Term Care Supports & Services

Single Point of Entry Informational Forum
August 28, 2006

## Participant Questions and Responses

### Nursing Home Transition to the Community

**Q1** *If we have residents in Macomb County who live in Wayne County/Detroit, will we be able to refer them to the Detroit SPE for services? Will they have to go to the site, or will services be offered "in home" as well?*

**A1** Detroit SPE services are available to any person who resides in its geographic service area. Options counselors will be available to make in-home visits if necessary to meet the needs of the consumer.

### Hospital Discharge Planning

**Q2** *How will discharges from hospitals be affected?*

**A2** The aim of having a single point of entry entity involved with individuals hospitalized and in need of long-term care services is to assist these individuals and those closest to them in knowing options available, and in accessing those options that are preferred by the individual. Thus, the point of involvement for options counseling is at the earliest point at which it appears that LTC services will be needed. This may not be known until some time during the course of hospital care, but in some cases it may be a matter known at the point of admission or even prior to that point. Early involvement will best assist the individual as well as health care providers in partnering to provide prompt information and options counseling. Local memorandums of understanding between the hospital and the SPE are intended to assure that options counselors are readily available, even co-located in hospital settings, to assist informed decision-making prior to discharge for the hospital patient in need of long term care services. Options counselors will not impede the discharge process; their involvement ought to facilitate the best outcome for the individual at that time, and in doing so, aid the hospital in achieving a timely and appropriate discharge.

**Q3** *Will the SPE be involved at the hospital level in terms of discharge planning and does it involve just Medicaid patients?*

**A3** Through local memorandums of understanding, the SPE will have options counselors available to serve all hospitals in the SPE's geographic service area. The options counselors will assist the hospital's discharge planners in planning for the patient's post-hospital residential arrangements and care needs.

## Coordination

**Q4** *What coordination will be required between the Detroit SPE and the Henry Ford PACE program?*

**A4** While not required, coordination between programs is encouraged to ensure that individuals are provided with the information and assistance needed to plan for and access long term care services. At a minimum, as the primary point of entry into Medicaid-funded long term care services, the SPE will act as a referral source for individuals wishing to enroll in the PACE program where one exists.

**Q5** *How will the SPE affect the LTC counseling currently done by CBC and MMAP? Both programs have a long history of providing this service.*

**A5** It is expected that the SPE will work closely with local stakeholders, including CBC and MMAP, to ensure the efficient and effective delivery of options counseling to individuals who need it. It is anticipated that CBC and MMAP will be collaborative partners of local SPE entities, acting as both a source of referrals for as well as the recipient of referrals from the SPE. Both are important partners in delivering benefits counseling services in the community.

**Q6** *Will the SPE demonstration projects be coordinated with the joint DCH/MSHDA affordable assisted living initiative that was recently unfolded?*

**A6** Yes to the extent they are serving the same geographic service area. SPEs will be responsible for working with both residents and housing managers to provide information and assistance in long term care residential planning. They will further be responsible for conducting level of care determinations for individuals wishing to access Medicaid-funded supports and services and facilitating person centered planning.

**Q7** *When do you anticipate the beginning of operational interface/referrals into the PIHP systems and supporting/serving the developmentally disabled population? How can PIHPs and supports coordinating agencies assist in the process?*

**A7** The SPEs are intended to serve the elderly and adults with disabilities. The only planned interface with the mental health/developmental disabilities PIHP system is for those individuals who are eligible for and require services from that system whose initial contact is with the SPE entity, and for those who may require LTC services in addition to services available through the mental health/developmental disabilities system. Individuals who are eligible for services through the public mental health system are the responsibility of the mental health/developmental disabilities system.

**Q8** *Can you explain the impact of the SPE on OBRA and dementia exception status?*

**A8** The SPE has no impact on OBRA.

## Intake

**Q9** *How will this affect the admission process to nursing homes?*

**A9** Because use of the SPE is not mandatory, the initial affect on nursing homes will be limited. It is hoped that nursing homes will voluntarily partner with SPEs to conduct the required level of care (LOC) determination for new admissions. As an incentive, MDCH aims to develop policy guidance that will not hold nursing homes responsible for the cost of care provided to individuals who are incorrectly deemed eligible by the SPE using the LOC tool.

**Q10** *Last year the state rolled out a level of care determination tool to determine if a person is appropriate for nursing home care. Will there be an equivalent objective tool across all levels of care or will the appropriate level of care be determined subjectively.*

**A10** Medicaid law and regulation dictates that a state utilize the same method to determine eligibility for LTC for nursing facilities, PACE programs and the state's Home & Community Based Services programs, in Michigan's case, MI Choice. If and when the LOC methodology is modified, it will be applied in a similarly standard manner. Therefore, eligibility for nursing facility care will not be determined in a subjective or arbitrary manner.

## Training

**Q11** *Will there be a statewide uniform training curriculum for SPE staff including specific modules in issues such as mental health, younger disabled consumers, dementia, etc.?*

**A11** To achieve a consistent and quality response across demonstration sites, uniform guidance will be provided. Local SPE entities will also be expected to work with their local counterparts in assuring that these needs and service options are commonly understood at the local level.

**Q12** *How are you involving/educating case managers and social workers in the acute care settings about the SPE program in an effort to better educate/direct their clients to the appropriate settings and services post a hospital stay?*

**A12** A primary focus of SPE outreach will be to work with acute care practitioners to increase their knowledge and acceptance of post-hospitalization options other than nursing facilities. To the extent that these practitioners are unaware of all of the options for LTC supports and services, they will be unable to assist in helping individuals know the range of opportunities.

## Housing

**Q13** *Will Medicaid pay for assisted living services if the consumer desires?*

**A**13 Currently, the MI Choice waiver may provide services to individuals who live independently, so those residing in unlicensed assisted living settings may receive support from the MI Choice program. At this time, the MI Choice waiver program does not provide services to individuals who are cared for in licensed residential care (Adult Foster Care or Homes for the Aged) settings

that are unlicensed. The Long-Term Care Task Force recommended that this option be added to the Medicaid program. Therefore, during the upcoming planning process for the MI Choice waiver renewal application, this option will be carefully considered. It is felt by many that individuals who now have no choice, but to enter a nursing facility when MI Choice waiver services in their home are not working, would be able to receive appropriate care in specialized licensed residential settings, were the MI Choice waiver program to include this option. Making this change will necessitate a careful examination of approaches to meet the added cost of this waiver service. Medicaid, however, may not be used to pay the costs of room and board in these licensed residential settings; Medicaid only pays the cost of room and board, in addition to care, in licensed institutional care settings, e.g. hospitals and nursing facilities.

**Q14** *If Medicaid money is used for AFC and assisted living, will there be regulations and inspections like nursing homes?*

**A14** "Assisted living" is not a statutorily defined type of care. Some settings denoted as assisted living are unlicensed; others are licensed. In unlicensed settings the individual is deemed to be in an independent living arrangement and existing MI Choice waiver program standards apply. In a licensed setting, the provider has a statutorily defined responsibility to assure for room and board as well as care, and the resident is typically dependent upon the provider. Licensing requirements impose standards for the care and residential support that must be furnished by the provider, and there are annual inspections as well as complaint investigations. The regulations governing these, however, are not the same as those governing nursing facilities. If the MI Choice waiver is expanded to pay for care in licensed residential care settings, there will likely be a set of standards that accompany the use of these specialized funds as there are for the use of specialized funds for such settings through the mental health system. To date, no planning work has been conducted towards this expanded option.

**Q15** *As assisted living facilities pop up and offer increasingly more "clinical" services, will the state take an active role in regulating them?*

**A15** In Michigan, assisted living is a marketing tool to describe housing with supports; there is no current governmental denotation of any care arrangement as "assisted living." Adult foster care homes and homes for the aged are housing with supports models that are licensed by the state. The OLTCSS is concerned that consumers be protected from misleading marketing and will examine options for regulatory and other mechanism to support quality. State regulation of unlicensed assisted living would require a statutory basis in legislation enacted by the Michigan Legislature.

**Options Counseling**

**Q16** *Is there a definition of options counseling in place? How does it differ from care management?*

**A16** A care manager conducts the assessment and leads the service planning process for an individual eligible for MI Choice services, using a person-centered planning process. The care manager subsequently oversees the authorization of services in accordance with the service plan, then monitoring the provision of those services by providers chosen by the person who furnish the

services. An options counselor works with the individual in need of LTC assistance along with others the individual chooses to involve, in order to assist the person to examine available options and to facilitate an understanding of options in line with the person's preferences. The options counselor may even assist the person to develop a general support plan, and will assist them in understanding and obtaining access to desired services. Options counselors may, with the agreement of the person, periodically review the person's service arrangements and assist them with transitioning from one care arrangement to another over time, based on need and preferences.

**Q17** *Will options counselors perform a thorough assessment of consumers' needs, strengths, dreams, etc.?*

**A17** Options counselors will engage individuals in need of LTC assistance in a dialogue to determine needs, strengths and preferences, including facilitation of discussions among the person and those closest to them about options and how they may align with the person's preferences. Individuals will be provided with information about all long term care options and assisted to examine how these meet their needs and preferences. A general plan support plan incorporating the consumer's choices will be developed. Referrals to providers will be made based on the plan. Options counselors will also conduct the functional eligibility determination and will assist in preparation of application for financial eligibility.

**Q18** *Will options counselors follow consumers from one setting to another? How will that take place?*

**A18** Options counselors will maintain regular contact with consumers, they will review with the consumer their goals and expectations. Help with transition from one setting to the next, when desired, will be provided.

**Q19** *If the SPE won't be developing person centered plans, will every provider be required to develop a person centered plan?*

**A19** The options counselors will develop, with the consumer a general support plan that identifies settings, but does not provide for the detailed care assessment or care plan that would be done by the consumer's chosen provider. This will be done using the principles of person-centered planning. The general support plan will give the provider a good basis for understanding the client's preferences and choices. The provider will be expected to develop the individual's specific plan of services and supports, and to authorize needed services as a result, within the scope of the provider's responsibilities. In doing so, the provider should use a person-centered planning process which engages others chosen by the consumer, and which facilitates discussion of the person's whole life, their preferences and the best way to meet their long-term care needs in ways that achieve those preferences.

**Impact on DHS**

**Q20** *As the SPE progresses and information and assistance expands, DHS workers – Medicaid and Adult Home Help Workers – will be greatly impacted. How do you plan to offset the increased workload for these DHS workers?*

**A20** DCH has committed to work in partnership with DHS to measure the added impact this initiative has on DHS workers. A process will be developed jointly with DHS to establish baseline workload demands and track change on a county-by-county basis, ascertaining the extent to which changes are due to SPE activity. The two Departments are committed to jointly advocate for increased funding through the state budget process to address identified staffing shortages, should they occur, within the SPE counties.

**Impact on MI Choice Waiver**

**Q21** *How many new waiver slots will be available so that SPEs can offer real choices?*

**A21** The original intent was to assure 350 waiver slots for use within SPE regions. The segmenting of the LTC funds to separate appropriations lines in the MDCH FY 2007 budget may impede achieving this intent, as funds cannot be made readily available by the department for additional waiver slots. The department will continue to monitor the costs and projected savings associated with SPE activity. As the state's budget permits, MDCH will work with the legislature to expand the number of MI Choice waiver slots that might be made available to the SPEs. It is expected that a better sense of how to address this need can be accomplished within the next three months.

**Q22** *How can you offer true options when there is a 3,000 person waiting list for the MI Choice waiver right now?*

**A22** It will be a challenge; without sufficient resources the options will necessarily be limited. The SPE demonstrations were never intended to be the single method by which the many issues involving LTC and resource needs should be addressed. Concerned parties must continue their advocacy roles. Progress toward increasing options in the delivery of LTC supports and services in different settings will be incremental. A pivotal role of the SPE will be to quantify the need for expanded community-based care options and demonstrate the necessity for implementation of funding mechanisms that allow money to follow the person into their desired setting of care. In any event, the SPE will be in a good position to monitor need and demand, and measure actual disposition and cost-benefits as compared to desired disposition and alternative cost-benefits.

**Q23** *How do you anticipate access to the MI Choice program changing in regions with SPEs?*

**A23** The MI Choice program is not being changed in those areas with SPE demonstration projects. If the department can find ways to provide increased waiver options in the SPE regions, a method for authorizing access to these waiver options will be developed such that an individual may choose their preferred waiver agent though which they may use their waiver option. But at this time, this is merely a concept. SPEs will play at critical role in linking individuals in need of and who desire community-based long term care with a local waiver agency for ongoing case management and delivery of in-home services. It is also expected that SPE demonstration projects will enter into collaborative agreements with the MI Choice waiver agents in order to conduct the level of care eligibility determinations for those under consideration for MI Choice.

**Miscellaneous**

**Q24** *Can you walk us through a "typical SPE scenario" for John Doe, age 67, on Medicare and Medicaid, currently in an acute care hospital, will need nursing home care, then home health services. How will a SPE assist John?*

**A24** A hospital discharge planner will engage an SPE options counselor to evaluate John's functional eligibility for long term care while still in the hospital. Using a person-centered planning process, the options counselor and John (and his chosen allies) will discuss his strengths and preferences and how his needs can be met within these preferences. During and as a result of this process, John and his chosen allies are better supported to evaluate options and make service decisions. The options counselor will assist him with accessing his desired service options for which he is eligible. The options counselor will contact John subsequent to his discharge (including during a Medicare-covered skilled nursing facility stay) to discuss ongoing needs, experiences and preferences and to continue to assist with knowing the full range of options available. If John is in a nursing facility and expresses a desire to live elsewhere, the options counselor will assist John in planning his transition.

**Q25** *Please explain how this process will work if either I am a consumer seeking help or a social worker advocating on behalf of a consumer needing more care.*

**A25** Whether you are a consumer or a social worker advocating on behalf of a consumer, a call to the SPE will result in a telephone conversation to determine the information and assistance needs. When appropriate, an in-person interview between the options counselor, the consumer and his/her chosen allies to review options and begin the planning process will be arranged.

**Q26** *Since the SPEs are funded by Medicaid, obviously Medicaid recipients will be served free of charge. Is it anticipated that SPE services will also be provided to those who are not eligible for Medicaid on a fee-for-service basis? How might this work? Will this be required of the SPEs?*

**A26** Information and assistance will be provided to all callers at no charge. Individuals who are not financially eligible for Medicaid will be offered an opportunity to participate in options counseling on a cost-shared or fee-for-service basis. This effort is essential to helping individuals with resources to plan for and access desired services. A primary goal of the SPE is to assist all Michigan citizens with LTC needs. Aiding individuals with resources may assist them in efficiently using their own resources to meet LTC needs, and thus delay their need for Medicaid funded services.

**Q27** *Where does home health care fit into the SPE process?*

**A27** Home health care services funded by Medicare and/or Medicaid must be prescribed by a physician. The SPE will help individuals and their caregivers to understand the range of available benefits and assist them in accessing the services they choose. Each SPE is developing an expanded resource data base that will include such services. In addition, it is expected that information to help callers be informed shoppers will be provided.

**Q28** *The Office of LTC Supports and Services has a great deal of staff with background/ expertise with the AAAs and MI Choice Waiver. What expertise and experience does this office have regarding the DHS home help services program and Medicaid eligibility?*

**A28** The OLTCSS has staff experienced with Medicaid eligibility determination process, as well as staff very familiar with the Home Help program. When its staff does not have knowledge or experience in a particular area, the Office will collaborate with staff from other departments and agencies. Policy changes and enhanced dialogue will occur through an interagency workgroup.

**Q29** *What plans do you have to fund an external advocate for the SPEs as recommended by the Task Force?*

**A29** Even though supported by Task Force recommendations, funding is not available at this time to fund an external advocate. In the absence of an external advocate, the Office is committed to ensuring that protocols are in place to ensure that Medicaid persons served by a SPE are fully informed of their right to a fair hearing, and that grievance and appeals processes are in place to resolve issues for non-Medicaid persons. Discussions will continue on external advocacy and its specific role, as well as an examination of the funding options that might be tapped to provide external advocacy.

**Q30** *What are the locals doing about assuring an external advocate is available from the beginning?*

**A30** Each SPE is creating partnerships at the local level that will have, or in the future will have, an ombudsman program.

**Q31** *Since these are pilot projects was consideration given to testing different design models?*

**A31** Many models were considered. The existing pilots are using several approaches to partnership, governance, and purchased services. In all cases, the pilots are working to build on existing services and to not duplicate services.

**Q32** *What is the rationale for not awarding planning grants to previous applicants?*

**A32** DCH wants to ensure the broadest participation possible in the local planning process and believes that awarding a planning grant to a neutral entity (i.e., a community college or regional United Way) will achieve that result. It would be perceived as creating an unfair advantage if applicants in the initial round were provided planning grants when other interested parties are not.

**Q33** *If the SPEs will cost $34 million over 27 months, why is only $9 million budgeted for SPEs in the '07 budget?*

**A33** When the budgets for the entire 27 month period of the demonstration project were being allocated, it was believed that it would take the SPEs a period of time to "ramp-up" to full operations. If it turns out that the SPEs are able to do this sooner, adjustments can and will be made in budget allocations for the project.

**Q34** *Is the LTC office pursuing all avenues to make mandatory referral a reality? When will that happen?*

**A34** The Office is not currently pursuing mandatory referral, as this appears to be not possible in a partial SPE system. Mandatory referral for LOC determinations is a component of pending legislation (HB 5389) and is desirable in the long run. Discussions with the CMS regional office are being planned to ascertain whether it is possible under current regulations to put a mandatory referral process in place.

**Q35** *Please explain the component of local partners under the SPE project. What types of providers, services, agencies, etc., can become a local partner? How do I, as a provider, go about establishing a local partnership with the SPE in my area and what can I do to ensure this partnership flourishes (is very active)?*

**A35** SPEs were required to involve consumers and local stakeholders in the planning process. The variety of stakeholders varies from one site to the next but is intended to include consumers, advocates and providers at a minimum. Any interested party can participate as a local stakeholder, providing input at public forums, and volunteering to serve on local workgroups and committees. Those interested in participating in local planning and governance should contact the SPE in their area to inquire about the process being used to involve stakeholders.

**Q36** *Please explain in more detail the nomination processes for governing* and advisory board. Who will be eligible to serve? How does one get nominated? Etc.?

**A36** Boards will be comprised of primary and secondary consumers as well as provider organization representatives. Individuals wishing to participate in governing and advisory boards at the local level should contact the individual SPE in their area for information on how to apply.

**Q37** *Please tell us about the extent of consumer involvement in the workgroups and how that can be expanded?*

**A37** Consumers are to be heavily involved at the local level in the initial planning, development, and ongoing governance of the SPEs. Four members of the LTC Commission are active in three of the state-level workgroups. These commissioners are consumers and represent consumers. It is the position of the OLTCSS that consumers can have the greatest impact participating at the local level, where operating processes and protocols are developed and implemented.

**Q38** *Are you expanding to all Michigan counties and when?*

**A38** The Legislature initially wants to keep the demonstration to the four identified service areas and requires an evaluation prior to expansion. Depending on successful outcomes, the initiative is planned to go statewide at the conclusion of the demonstration period in FY 2009.

**Q39** *Mike mentioned that creating independent agencies is a national trend for SPE development. Can you identify some other states using this design?*

**A39** Florida passed single point of entry legislation that prohibits direct providers of service from being a SPE. Aging and Disability Resource Center grantees in AK, IA, LA, ME, NC, NM, and WV provide SPE functions but not waiver or other provider functions. New Hampshire and Wisconsin have detailed conflict of interest components; in Wisconsin, the Aging & Disability Resource Centers are separate from the Family Care plans.

**Q40** *In many of the past discussions about SPEs, the concept of no wrong door was changed to a single point of entry. Can you elaborate on your concept of no wrong door?*

**A40** The goal is that consumers, regardless of where they call or inquire, would receive good information and connection to staff from the SPE. This is achieved through communication and shared training offered in SPE regions.

**Q41** *Can you create a website for posting all kinds of materials from the SPE demonstrations, Commission, PCP Action League, Legislature, etc.?*

**A41** A website has been created at www.michigan.gov/ltc to keep interested parties informed about Commission and Office activities, SPE demonstration projects, and other related long term care systems change issues. A page with SPE demonstration project information and updates will be available in the very near future.

**Q42** *Can we get copies of today's power point presentations?*

**A42** Copies are available at www.michigan.gov/ltc.

Michigan Department of Community Health

MDCH

Jennifer M. Granholm, Governor
Janet Olszewski, Director

# YOU ARE INVITED TO ATTEND

**THE**

# "SINGLE POINT OF ENTRY" INFORMATIONAL FORUMS

## October 23, 2006
## Michigan Home Health Association

2140 University Drive, Suite 220, Okemos, Michigan (517) 349-8089
(Directions on back)

## November 27, 2006
## Michigan Library & Historical Center, Auditorium

702 West Kalamazoo, Lansing, Michigan
(Directions on back)

## 10:00 am – Noon

An informational session for stakeholders and persons interested in learning about the newly forming Single Point of Entry for long-term care services in Michigan. Presentations will be followed by a question and answer period.

**Sponsored by the Office of Long-Term Care Supports & Services**
**Michigan Department of Community Health**

For More Information: 517.373.3860 or thelen@michigan.gov **RSVP not required.**

*The Single Point of Entry will be a highly-visible and trusted source of information and assistance about long-term care, aiding Michigan residents with planning and access to needed services & supports, in accordance with their preferences.*

# October 23, Michigan Home Health Association

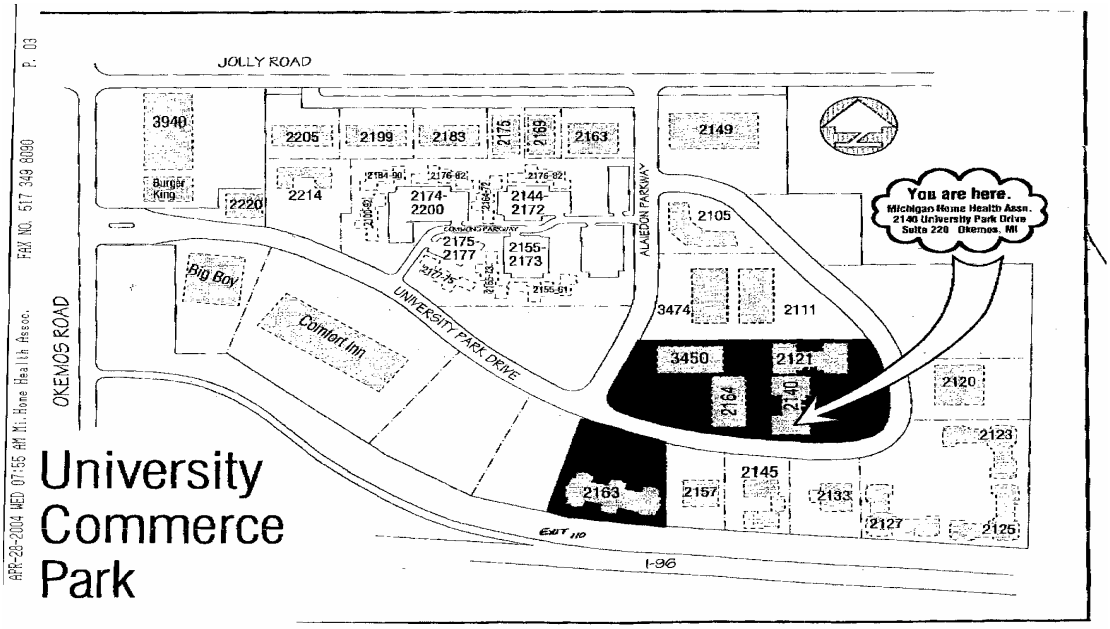
## 2140 University Drive, Suite 220, Okemos, Michigan (517) 349-8089

**From I-96:** Take Exit 110 (Okemos Road) north to University Park Drive East (large green sign - University Commerce Park). (see map below)

**From US 127:** Take I-96 East (Detroit) to Exit 110. See above

**From I-69 East:** Take East Lansing/Haslett Exit to Marsh Road. Turn left (south) to Grand River Road. Turn right (west) to Okemos Road. Turn left (south), go past Jolly Road. You will see a large green sign - University Commerce Park on your left (west). Turn left. (See map below).

**From I-69 West:** Take I-96 East. See above.

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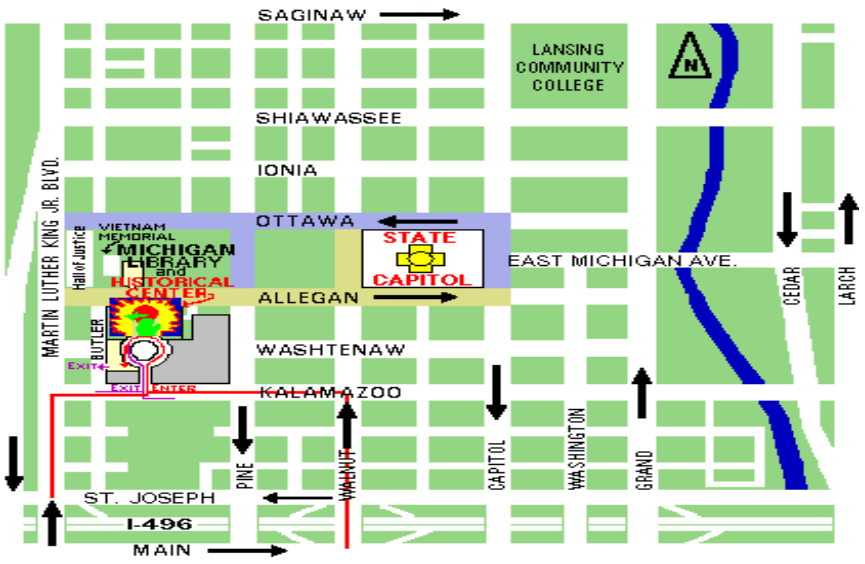
# November 27, Michigan Library & Historical Center Auditorium

702 West Kalamazoo, Lansing, Michigan

The Michigan Library and Historical Center visitor parking is on the north side of Kalamazoo Street, two blocks east of M. L. King Jr. Boulevard.




# Michigan's Long Term Care Connections

## Work Group Updates

**Nora Barkey**
**Office of Long Term Care Supports and Services**

# A Briefing

- Today's Focus:  4 Work Groups
  - Functions
  - Management Information System
  - Interagency
  - Training
- The Plan
  - Update
  - Introduce Local SPEs

# Workgroup: Functions

- Meets bi-weekly
  - Product: ***Information and Assistance***
    - Draft standards built around AIRS standards
    - Resource Data Base Taxonomy Agreements
      - Accommodate aging and disability issues
      - Easily integrate with 211
  - Process
    - Dialogue and Drafts
    - Review plans: consumers and person with knowledge in issue areas like dementia, health promotions, rights etc and OLTCSS for contractual requirements

# Workgroup: Functions

- Develops ***Options Counseling***
  - Designs work flow
  - Integrates Person-Centered thinking
  - Includes specific supports for caregivers
  - Promotes Health Self Management
  - Provides Benefits experts
  - Supports transitions
  - Promotes Long Term Care Planning
  - Defines Crisis Management functions

# Workgroup: Management Information System

- Meets bi-weekly
  - Product: ***Service Point Design and Installation***
    - Data elements for Information and Assistance that will track information about callers, referrals, service needs, unmet needs
    - Design for ***Assessments*** and ***Level of Care Determination***
    - Incorporating evaluation data elements

# Workgroup: Interagency

- Product: ***Memorandum of Understanding***

  between the Department of Community Health, the Department of Human Services and the Office of Service to the Aging
- Policy Issues
  - Access
  - Training for LOC determination
  - Bench mark data from existing systems (financial eligibility)

# Workgroup: Training

## Products

- ***Training agenda*** and learning objectives
- ***Identify Resources and trainers***
  - Person Centered practices  September 2006
  - Rhonda Montgomery PhD  September 2006

## Process: A virtual workgroup

# Learning Organizations

- Learning organizations are organizations where people continually expand their capacity to ***create the results they truly desire***; where new and expansive patterns of thinking are nurtured; where collective aspiration is set free; and where people are continually ***learning to see the whole together***.

--Peter Senge, *The Learning Organization*

# "Create the results they truly desire…"

- The MLTCC will ***improve access*** and ***enhance consumer control*** by providing information and assistance to
  - individuals needing either public or privately-funded services;
  - professionals seeking assistance on behalf of their clients; and
  - individuals planning for their future long-term care needs.

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Prepared 9/27/2006

**Recommendation # 1: Require and Implement Person-Centered Planning Practices.**

| ***Recommendations* for State Activities from the Task Force** | **Progress of state agencies and policies** | **Next Steps for OLTCSS Commission** | **Timeframe** |
|---|---|---|---|
| 1. Require implementation of person-centered planning in the provision of LTC services and supports. Include options for independent person-centered planning facilitation for all persons in the LTC system. | | | |
| 2. Revise health facility and professional licensing, certification criteria, and continuing education requirements to reflect a commitment to organizational culture change, person-centered processes, cultural competency, cultural sensitivity, and other best practices. | | | |
| 3. Require all Single Point of Entry agencies to establish and utilize person-centered planning in their operations. Review and refine practice guidelines and protocols as part of the first year evaluation of the SPE pilot projects. | | | |
| 4. Include person-centered planning principles in model legislation to amend the Public Health Code. | | | |

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| 5. Early in the implementation process, ensure the provision of training on person-centered planning to long-term care providers, regulators, advocates, and consumer. | | | |
| 6. Require a continuous quality improvement process to ensure continuation and future refinement of person-centered planning in all parts of the system. | | | |

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**Recommendation #2: Improve Access by Adopting "Money Follows the Person" Principles.**

| ***Recommendations* for State Activities from the Task Force** | **Progress of state agencies and policies** | **Next Steps for OLTCSS Commission** | **Timeframe** |
|---|---|---|---|
| 1. Establish consistent spend down provisions across all long-term care settings. | | | |
| 2. Establish funding mechanisms that abide by the "money follows the person" principle. | | | |
| 3. Amend and fund the MI Choice waiver to serve all eligible clients. | | | |
| 4. Establish reimbursement levels that realistically and appropriately reflect the acuity level and need for services and supports the client needs, consistent with federal limitations. (An immediate step would be to remove the current reimbursement cap on the MI Choice waiver.) | | | |

**Recommendation # 3: Create Single Point of Entry Agencies for Consumers.**

| ***Recommendations* for State Activities from the Task Force** | **Progress of state agencies and policies** | **Next Steps for OLTCSS Commission** | **Timeframe** |
|---|---|---|---|
| 1. Determine financial eligibility through the appropriate state agency. The process of determining eligibility also helps capture other public and private assistance programs for which the person is eligible. The SPE agencies will provide assistance to consumers in working through the eligibility application process. Single points of entry can facilitate speedier processing and identify barriers to processing. SPE agencies should work with other agencies to resolve barriers found in the system. | | | |
| 2. Make supports coordination a key role of the SPE agencies. Consumers have the ability to change supports coordinators when they feel it is necessary to do so. Individuals should develop their support plans through the person-centered planning process. If the consumer chooses a supports coordinator from outside of the agency, the outside supports coordinator is held to the same restrictions on financial interest and should be held to same standards as SPE supports coordinator. The SPE retains the responsibility of authorizing services.<br>a. The consumer can choose to have their supports coordinator broker their services or may broker their own services - | | | |

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| whichever they prefer.<br>b. The SPE agency will develop a protocol to inform consumers of their right to change supports coordinators.<br>c. Establish methodologies to facilitate consumer control of what, by whom, and how supports are provided. Included will be methodologies for consumers to control their budgets or authorizations. | | | |
| 3. Make LTC transition a function of the SPE agencies. This service helps consumers make decisions about their own lives and facilitates a smooth transition between settings as their needs and preferences change. | | | |
| 4. Balance LTC through proactive choice counseling. The goal of proactive choice counseling is to catch people with LTC needs at key decision points (such as hospital discharge) and provide education and outreach to help them understand their options. Involve hospital administrators and social workers in developing protocols for the two systems to work together. This will involve outreach by the SPE to hospitals to explain their functions and benefits. Do outreach to the local physician community as well as other interested parties (Adult Protective Services, police, and others) working in settings where critical decisions are made about | | | |

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| long-term care. | | | |
| 5. Mandate use of the SPE agency for individuals who seek to access Medicaid-funded programs. Individuals who are private pay will be able to access all of the services of the SPE agency. The Information and Referral/Assistance functions will be available to everyone at no cost. Private pay individuals may have to pay a fee to access other SPE services (such services may be covered by long-term care or other insurance, however). LTC providers will be required to inform consumers of the availability of the SPE agency. | | | |
| 6. Make a comprehensive assessment, or level of care tool, (developed by the proposed LTC Administration) available from the SPE agencies to determine functional eligibility for publicly funded LTC programs including Home Help, Home Health, Home and Community Based Services waiver (MI Choice), and nursing facilities. SPE agencies will use the Comprehensive Level of Care Tool for <u>all</u> persons coming to the SPE for assessment. The LTC Administration or MDCH is responsible for the development of the comprehensive tool. The SPE is responsible for ensuring the Preadmission Screening and Annual Resident Review (PAS/ARR) screen is done by the responsible agency when appropriate. | | | |

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| 7. Require providers of LTC services to offer the Level of Care Determination Tool to private pay consumers. If a provider feels it cannot perform this assessment for the consumer, the provider should avail itself of the SPE agency's ability to perform this function. | | | |
| 8. Locate functional eligibility determination in the SPE agencies as long as there is aggressive state oversight and quality assurance including: 1) SPE agency required procedures to prevent provider bias and promote appropriate services; 2) SPE agency supervision, monitoring, and review of all assessments and support plans/care coordination; 3) state quality assurance monitoring; and 4) consumer advocate and ombudsman monitoring. | | | |
| 9. The SPE agencies cannot be a direct provider of services to eliminate the tendency to recommend its own services to consumers and any other conflicts of interest. (An exceptions process must be developed to address service shortfalls, but in no event shall a SPE be a direct provider of Medicaid services.) The case management currently done by Waiver agents would be provided through SPE agencies under this system. The case management done by Department of Human Services (DHS) for Home Help would be provided through SPE agencies in this system. SPE agencies | | | |

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| will encompass the entire array of Medicaid funded LTC supports. | | | |
| 10. The funding for defined single points of entry is estimated to be between $60 and $72 million statewide. Of this total, approximately $31 to $36 million represents "shifted" dollars from current case management resources, while the remaining amount reflects newly committed dollars needed for this purpose. The annual state share of newly committed dollars upon full implementation (at the end of year 3) will be $15 to $20 million. The Medicaid administrative matching formula should be used as the means of funding the SPE system.<br><br>The SPE system will be phased-in over a three-year period. The estimate for first year costs for three SPE agencies is $12 to $16 million total funds. The State's GF contribution would be $6 to $8 million of which $3 to $4 million would be cost-shifted. SPEs will be routinely evaluated to ensure the needs of consumers are being met effectively and efficiently. A system wide efficiency gain of 1.7% in LTC expenditures as a result of establishment of single points of entry will fund the entire state system. | | | |
| 11. Develop a standard set of training and certifying criteria for SPE agencies set by the state. By establishing a standard set of | | | |

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| certifying criteria, the state will be able to establish quality assurance measures that will provide consistency for consumers and stakeholders. Part of the standard criteria should be a demonstrated knowledge of local and regional resources to supplement Medicaid-funded supports. | | | |
| 12. Standardize the tools used by SPE agencies to allow for portability of benefits for the consumer if they move between regions as well as standardization of data collection for the state. | | | |
| 13. Ensure access to bilingual and culturally competent staff at single points of entry who are trained according to the requirements of the SPE agencies. | | | |
| 14. Implement a quality assurance function focused on the SPE agency that emphasizes, but is not limited to, measures of consumer satisfaction. | | | |
| 15. The state needs to establish a comprehensive oversight system to ensure that all LTC consumers receive those supports and services set forth in their person-centered plan in a timely manner and that the supports and services are of the highest quality possible. Quality in this context will be measured by the consumer's satisfaction or lack thereof with the supports as provided. | | | |
| 16. Expand advocacy processes for | | | |

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| all LTC consumers. An advocate must be designated and legally granted the duty and authority to advocate on behalf of individual long-term care consumers, since much expertise is required for effective advocacy. The advocacy function also needs to have a systemic approach to advocacy, similar to that performed by the State Long-Term Care Ombudsman or Michigan Protection and Advocacy Services. This more systemic approach would provide greater opportunity for the advocacy group to determine if there are any patterns of policy violations by SPE agencies or for patterns of misunderstandings of the policies by consumers or providers. | | | |
| 17. Develop grievance and appeals processes that empower LTC consumers to challenge any denial of a requested support or any reduction, termination, or suspension of a currently provided support. The grievance process must be available not only for those issues, but also for issues not typically subject to the appeals process (such as the choice of provider). | | | |

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Prepared 9/27/2006

**Recommendation # 4: Strengthen the Array of Services and Supports (Expanding the Range of Options).**

| ***Recommendations* for State Activities from the Task Force** | **Progress of state agencies and policies** | **Next Steps for OLTCSS Commission** | **Timeframe** |
|---|---|---|---|
| 1. Ensure the availability of the health and long-term care services and supports (listed on Chart 1) as part of an integrated system of care. | | | |
| 2. Immediately amend the MI Choice waiver to allow the provision of waiver services to individuals residing in licensed assisted living settings including adult foster care homes and homes for the aged. In addition to this short-term strategy, take measures to ensure that all future comparable Medicaid programs allow supports and services to follow consumers into their preferred living arrangement (money follows the person). | | | |
| 3. Revise Adult Foster Care (AFC) and Homes for the Aged (HFA) rules and regulations to allow for the provision of home health care in AFCs and HFAs on an ongoing basis. | | | |
| 4. Consider creating a HFA statute separate from the Public Health Code. | | | |
| **5**. Create an Assisted Living Regulatory and Education Workgroup and charge with the following tasks:<br><br>a. Study and propose modifications to existing adult foster care and home for the aged state statutes and administrative rules for the purpose of ensuring that they | | | |

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| meet with the Task Force's stated philosophies and principles of quality and accountability; person-centered planning; money following the person and the availability of Medicaid reimbursement in assisted living (such as the MI Choice waiver or comparable community-based benefits).<br><br>b. Study the array of unlicensed assisted living arrangements. Determine whether existing licensing statutes are appropriately enforced to uphold the philosophies and principles stated above.<br><br>c. In cooperation with other Task Force initiatives, develop consumer education materials to be used by SPE agencies and others to raise consumer awareness about the full array of assisted living services using clear distinctions regarding the applicable state regulations.<br><br>Determine the feasibility and appropriateness of developing a legal definition of "assisted living" to allay public confusion as to the meaning of the term and its current use in describing a wide variety of licensed and unlicensed settings. | | | |

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Prepared 9/27/2006

**Recommendation # 5: Support, Implement, and Sustain Prevention Activities through (1) Community Health Principles, (2) Caregiver support, and (3) Injury control, Chronic Care Management, and Palliative Care Programs that Enhance the Quality of Life, Provide Person-Centered Outcomes, and Delay or Prevent Entry in the LTC system.**

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| 1. Convene a broad-based coalition of aging, disability, and other organizations. | | | |
| 2. Review community resources and needs (including prevention, chronic care, and caregiver supports). | | | |
| 3. Identify existing local, culturally competent strategies to address prevention, chronic care needs, and substance abuse. | | | |
| 4. Develop and support programs to address prevention, chronic care, and caregiver supports. | | | |
| 5. Promote the use of culturally competent caregiver training on injury prevention, rights and benefits, and person-centered planning. | | | |
| 6. Develop wrap-around protocols for caregiver/consumer support needs. | | | |
| 7. Develop a public health caregiver support model. | | | |
| 8. Create initiatives and incentives to support caregivers. | | | |
| 9. Identify and promote the use of elements of established models for chronic care management and coordination (e.g., Wagner or ACOVE model). | | | |
| 10. Create incentives for implementing culturally competent chronic care models and protocols. | | | |
| 11. Develop and implement chronic care protocols, including, but not | | | |

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| limited to:<br>a. medication usage.<br>b. identifying abuse and neglect, caregiver burnout/frustration.<br>c. caregiver safety and health. | | | |
| 12. Promote the use of Assistive Technology (AT) for consumers and direct care workers/caregivers as a prevention tool. | | | |
| 13. Investigate grant opportunities to pilot chronic care management models. | | | |

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Prepared 9/27/2006

**Recommendation # 6: Promote Meaningful Consumer Participation and Education by Creating a Long-Term Care Commission and Informing the Public about the Available Array of Long-Term Care Options.**

| ***Recommendations* for State Activities from the Task Force** | **Progress of state agencies and policies** | **Next Steps for OLTCSS Commission** | **Timeframe** |
|---|---|---|---|
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**Recommendation # 7: Establish a New Quality Management System.**

| ***Recommendations* for State Activities from the Task Force** | **Progress of state agencies and policies** | **Next Steps for OLTCSS Commission** | **Timeframe** |
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| 1. Develop and implement use of consumer experience/consumer satisfaction surveys and measurements. | | | |
| 2. Include a strong consumer advocacy component in the new system. | | | |
| 3. Review and analyze current performance measures (both regulatory and non-regulatory). | | | |
| 4. Design performance measures that move Michigan's LTC system toward this vision of quality. | | | |
| 5. Invest quality management functions in a new Long-Term Care administration. The administration would improve quality by consolidating fragmented pieces of LTC, and defining and establishing broader accountability across the LTC array of services and supports. [Section 7 of the model Michigan Long-Term Care Consumer Choice and Quality Improvement Act in the appendix discusses some of the quality management functions in detail.] | | | |

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**Recommendation # 8: Michigan Should Build and Sustain Culturally Competent, Highly Valued, Competitively Compensated, and Knowledgeable LTC Workforce Teams that Provide High Quality Care within a Supportive Environment and are Responsive to Consumer Needs and Choices.**

| ***Recommendations* for State Activities from the Task Force** | **Progress of state agencies and policies** | **Next Steps for OLTCSS Commission** | **Timeframe** |
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| 1. Develop within the Michigan Works! Agencies (MWA) network, recruitment and screening protocols and campaigns that meet the needs of employers and job seekers. | | | |
| 2. Recast the state's Work First program to recruit, screen, train, and support individuals who demonstrate the desire, abilities, and commitment to work in LTC settings. | | | |
| 3. Develop recruitment campaigns to attract men, older workers, people of diverse cultural backgrounds, and people with disabilities to long-term care careers. | | | |
| 4. Mobilize state agencies' activities to include the research, exploration, explanation, and promotion of career opportunities in long-term care. | | | |
| 5. Improve and increase training opportunities for direct care workers to allow for enhanced skill development and employability. | | | |
| 6. Increase training opportunities for employers to improve supervision and create a positive work environment. | | | |

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| 7. Reduce the rates of injury and exposure to hazardous materials to protect the current workforce and encourage new workers to join this workforce because of the sector's safety record. | | | |
| 8. Raise Medicaid reimbursement rates and other incentives so that the LTC workforce receives compensation necessary to receive quality care as defined by the consumer. | | | |
| 9. Expand the ability of all long-term care employers and their employees, particularly their part-time employees, to access affordable health care coverage for themselves and their families.<br><br>The Department of Human Services (DHS), Michigan Department of Community Health (MDCH), Michigan Office of Services to the Aging (OSA), Department of Labor and Economic Growth (DLEG) and other state agencies should work collaboratively to identify standards and benchmarks ensuring that direct care workers are key partners and team members in providing quality care and supports. | | | |
| 10. Develop health professional curricula and reform current practice patterns to reflect the changing needs of the population. Recognize the | | | |

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| unique needs of the elderly; people with chronic health problems; people approaching end-of-life; people of all ages with disabilities; and those in need of rehabilitative and restorative services across LTC and acute care settings. | | | |
| 11. LTC administration will track employment trends, including turnover rates. | | | |

**Recommendation # 9: Adapt Financing Structures that Maximize Resources, Promote Consumer Incentives, and Decrease Fraud.**

| ***Recommendations* for State Activities from the Task Force** | **Progress of state agencies and policies** | **Next Steps for OLTCSS Commission** | **Timeframe** |
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| 1. Current resources are not sufficient to adequately fund needed supports and services. | | | |
| 2. The demand for long-term care supports and services will continue to increase as the population ages and as longevity increases. | | | |
| 3. Medicaid dollars available to meet anticipated demands are already being fully utilized within the state of Michigan, and federal support for future increases does not appear likely. While some efficiencies and cost savings of Medicaid dollars may be realized as part of the process of this review of the long-term care system, these dollars should not be expected to be sufficient to resolve existing financial shortages. | | | |
| 4. State legislative leaders and state policy makers must assure that non-Medicaid resources currently available to the state continue to be used to offer long-term care services and supports for Medicaid and non-Medicaid eligible individuals. This principle should reflect the need to maximize the availability and the flexibility of all funding sources in providing access to long-term care services and supports for residents of the state. | | | |

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| 5. Leaders of the state's executive and legislative branches must acknowledge that while long-term care supports and services for the state's population must be adequately funded, this should not occur at the expense of, or detriment to, other vital state services such as public safety, public education, and the general public welfare. It is further incumbent upon the state's leadership and decision-makers to avoid the "pitting" of those in need of long-term care supports and services against the need for other public services in the allocation of currently scarce public resources. | | | |
| 6. The state must make a commitment to reinvesting all dollars realized from cost savings identified within the long-term care system back into long-term care supports and services. As changes to the system are recommended it is critical that any identified savings are not viewed as a way to help balance the state budget during a difficult economic period, but rather as a way to assure that an adequate system of long-term care supports and services is available to residents of the state of Michigan. | | | |